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**Knowing the body and embodying knowledge:
an ethnography of student practitioner
experiences in osteopathy and homeopathy**

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A thesis submitted in partial fulfilment of the
requirements for the degree of
Doctor of Philosophy in Sociology

University of Warwick, Department of Sociology

March 2007

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To my mother, Kay, the inspiration for this study.

Acknowledgements

With heartfelt thanks to all those who have supported and inspired me throughout this process.

In particular, thanks are owed to my two supervisors, Carol Wolkowitz and Simon Williams, without whose unwavering support and insightful guidance, I would have got very lost indeed on this journey; to my parents, Kay and Humphrey, and my brother, Jonathan, for their love, faith and support; to all my friends for keeping me sane, particularly Claire Warren and Al Cook who at points risked their own sanity to live with me, Donna Nelson, John Abell and Katherine Miles who regularly welcomed me into their homes when I stayed up at Warwick, and Jo Ward, Sarah Jenkins, Adél Várnai, Mike Schofield, Siân Emeny-Smith, James Black, Jenna Eastlake, Louise Evans, Adam Herriott, Clare Smith, James Turner, Maddy Young and Lois Duquesnoy; to my osteopath, Alex Johnson, and my homeopath, Susie Hodder-Williams for their wisdom; to all the staff members of the Department of Sociology at Warwick, particularly Liz Dowler, Elaine Welsh, Karen Throsby, Ann Ryan, Hannah Bradby, Mick Carpenter, Ian Proctor and Andrew Parker; to colleagues, particularly Wendy Martin, Nina Nissen, Alan Bradley, Liza Draper, Danny Beusch, Juliet Rayment, Maud Perrier, Natalie Pitimson, and all those at the ACHRN; to all my students at Warwick, Birkbeck and Westminster; to the ESRC for funding me, and last, but certainly not least, to all my participants who welcomed me into their lives for a year and showed me their world.

Declaration

I confirm that this thesis is my own work, and that it has not been submitted for a degree at another university.

Abstract

The subject of this thesis is the lived experience of training in non-orthodox health care professions, or CAM (complementary and alternative medicine) as it is commonly known. The thesis focuses both on the nature of the knowledge and skills acquired during training (knowledge of the body) and the changing embodiment of the students (embodying knowledge). It is based on ethnographic research, conducted over one academic year, at two case-study sites: the anonymized Colleges of Homeopathy and Osteopathy. The data presented in this thesis offers four distinct contributions. Methodologically, it offers insights into the embodied experience of conducting sociological research and the deep impact that this experience has on the researcher, further supporting the argument that reflexivity is a vital component of valid and reliable research. Empirically, it contributes to our understanding of an under-researched area, the practice of CAM therapies generally, and the training of practitioners particularly. Theoretically, the explicit focus of both the participants in the study and myself, as researcher, on ‘bodies’ makes it a worthwhile topic of study to contribute to the growing discipline of embodied sociology. Finally, from a social policy perspective, the explosion of interest in CAM in recent years, and particularly the growing pressure on practitioners to regulate their professions, makes research into the nature of professional knowledge and practice very timely. The thesis concludes that it is of critical importance to consider embodiment in any understanding of healthcare knowledge or practice. In particular, an embodied sociological perspective permits recognition of the depth and nature of the knowledge and skills that healthcare practitioners learn to deploy on a day-to-day basis.

Abbreviations used in this thesis

CAM	Complementary and Alternative Medicine
CBO	Conceptual Basis of Osteopathy (Course Unit - Osteopathy)
CORH	Council of Organisations Registering Homeopaths
CPD	Continuing Professional Development
GOsC	General Osteopathic Council
FD	Function Dysfunction (Course Unit – Osteopathy)
HVT	High-Velocity Thrust (Osteopathic Treatment Technique)
IMS	Involuntary Motion Studies (Course component (POS) – Osteopathy)
PC	Professional Capability (Course Unit – Osteopathy)
POS	Practical Osteopathic Skills (Course Unit – Osteopathy)
PPS	Personal Practitioner Skills (Course Unit – Homeopathy)
SF	Structure Function (Course Unit – Osteopathy)

Introduction

Ethnographic research into the training of osteopaths and homeopaths represented, for me, an opportunity to delve, with my ‘sociological imagination’ (Mills, 1959), into an area which is interesting both as a substantive empirical subject that is currently under-researched, and as a research tool to further contribute to theoretical questions about the role of embodiment in society. Non-orthodox forms of medicine have remained very much on the periphery of debates in the sub-discipline of sociology of health and illness, but with growing usage levels things are beginning to change. Research at training colleges for osteopaths and homeopaths offers uniquely promising settings for making explicit the embodied knowledge and skills that underpin day-to-day practice. Clearly, the bodies of patients are important to consider in this study, because students learn to understand the body in health and illness, and how to initiate the healing process; however, the practitioner body is also deeply implicated, especially through the interactional relationship in the consultation. Students learn new knowledge and skills which, in practice, are acquired and deployed through the body. A comprehensive consideration of the role of embodiment in practitioner training offers the potential for insights into the lived experience of the students, the nature of practitioner knowledge and skills, and the development of professional identity.

There is a great deal of diversity in the therapeutic practices that fall under the bracket of non-orthodox medicine, or CAM (Complementary and Alternative Medicine) as it is more commonly known, that range from acupuncture, to crystal

therapy, to aromatherapy, to Alexander Technique, to yoga, to forms of spiritual healing. Some are well-known and established, others rare or newly developed, some are deeply grounded in national cultures, others were developed by disillusioned orthodox practitioners, some are modern incarnations of traditional healing methods, while others have remained virtually unchanged for centuries. Saks argues that CAM is a social category, distinctive by its 'marginal position in the power relations surrounding health care' (1995: 104). Indeed, forms of medicine outside of the 'orthodox' medical sphere have often had a bad press with accusations including witchcraft, quackery or middle-class nihilism. However, there has been an explosion of interest in CAM in recent years, from its re-emergence in the 'hippy' years of the sixties and seventies, to more widespread, and increasingly mainstream use today. Alongside this growth in use has been a proliferation of courses training individuals to be practitioners.

In relatively recent history, the dominance of 'medical science' in the healing professions has led to the privileging of a body of knowledge that focuses on physical function – the body as machine – to the exclusion (or at least the sidelining) of the emotions, the mind, the social and the spiritual that many non-orthodox approaches claim are central to understanding health and healing. Most forms of CAM can neither be explained nor tested with orthodox scientific techniques. This issue is becoming increasingly debated as growing numbers of people train to be practitioners and there is a demand for 'better' standards of teaching (Select Committee on Science and Technology, 2000). There is a huge range of training courses, varying by style, length and qualifications gained, but what is being 'learnt' on these courses – the knowledge and skills deemed necessary for practice – is the subject of much interest and, frankly, suspicion. Most therapies claim some commitment to 'holism' or

‘vitalism’ – approaches that, while often having blurred definitions through overuse, reject mind-body duality and see the human body as a functioning ‘whole’ that is not reducible to its component parts. However, the implications of this for the knowledge and skills base of the practitioner can be interpreted in many ways.

As a substantive area of enquiry, the training of CAM practitioners is of significance to both sociology and social policy. For sociologists, the topic cuts across the sub-disciplines of health and illness, work and employment, education and the professions. Areas of interest include: ontological and epistemological questions about the knowledge and skills required for healthcare practice; the re/production of knowledge and skills within a professional group; the values assigned to different ways of knowing about the body and different forms of embodiment; embodied power in both the learning experience and the healing process, and the implications of different approaches to health and healing for the patient. In an educational environment, the lived body, with its ways of perceiving, thinking and interacting with the world, arguably changes more consistently and quickly than in other areas of life. In addition, it often brings the ‘body’ into sharp relief, as students experience the struggle and awkwardness of learning new skills and knowledge.

An empirical focus on the lived experience of the students also enables a re-focusing on the bodies of students. Healthcare professionals train for many years to learn more about the way that the body works and how to assess a body in disease and to assist in bringing that body back to health. There have been a number of influential studies of medical students (Atkinson, 1981; Atkinson, 1995; Becker et al., 1961; Fox, 1957; Good & Good, 1993; Merton et al., 1957; Sinclair, 1997). These studies tend to focus on the reproduction of knowledge, and the ‘professional socialization’ of students. There are two points of interest here: one is that medical knowledge is only

one way of knowing the body. This thesis looks at alternative approaches to healthcare practice to understand what sort of 'body' is envisaged. The second is that students do not passively absorb the knowledge and values of a unified profession; it is a much more complex process, in which the students are active constructors of their own reality, and professions are characterized by diversity and debate. An embodied approach potentially offers a greater appreciation of this process (see e.g. Lawler, 1991).

The rise of CAM and the training of practitioners also raises interesting questions for policy makers. CAM is rarely subject to the same intensity of regulation as orthodox medicine. However, its current popularity has raised questions from many quarters about whether it might be appropriate to increase that regulation, ostensibly for the 'protection' of patients. Some of the larger and more organised groups of practitioners, who have followed various professionalizing strategies, have started to take this route, with osteopathy and chiropractic now state-regulated professions in the UK and others, such as herbal medicine, acupuncture and homeopathy considering similar strategies. In particular, gaining understanding of the nature of the knowledge and skills acquired by graduates of training colleges is fundamental to the future regulation of the professions.

The explicit focus on the bodies of both patients and (student) practitioners in the educational setting provides a potentially rich source of data for explicating the theoretical issue of the role of 'the body' or 'embodiment' in society. Embodiment has become an increasingly popular subject as sociologists have struggled to overcome mind-body dualism, and to find a theoretical path between essentialism and constructivism. Feminist research has also criticized the associated mapping of the two sides of the mind-body dualism into a hierarchical gender dualism, and gender

remains a vital consideration in the study of health care, as women dominate on both sides of the therapeutic encounter, especially in CAM. Work in the sociology of embodiment has involved both the re-reading of older sociological texts ‘in a new, more corporeal, light’ (Williams & Bendelow, 1998: 2), and empirical work taking embodiment as a central theme. Areas of interest have included the body as a ‘natural symbol’ (Douglas, 1973), the discursive construction and regulation of bodies (Foucault, 1963), the management of the self through bodily deportment (Goffman, 1959), the phenomenological body (Merleau-Ponty, 1962), the production of ‘habitus’ (Bourdieu, 1977; 1979) and post-structuralist explorations of the ‘body without organs’ (Deleuze & Guattari, 1984 [1972]).

It is clear that the spectre of Cartesian dualism is beginning to be ousted from the faculties of sociology by the growth of work relating to both embodiment and emotions (Crossley, 2001; Jaggar, 1989; Leder, 1990; Martin, 1987; Shilling, 1993; Williams, 2001; Williams & Bendelow, 1998), including research in health care (Cassell, 1998; Fox, 1999; James & Gabe, 1996; Lawler, 1991; Sharma, 1996; Stacey, 1988), work (Hochschild, 1983; Wolkowitz, 2006), sleep (Williams, 2005), love (Jackson, 1993; Jaggar, 1989) and pain (Bendelow, 2000). At this time, therefore, research into therapies that challenge the orthodox medical model through their holistic emphasis seems timely. Through research on the lived experience of student practitioners, it is not only possible to continue to challenge the often cursory or reluctant attention paid to the body or the presumed division of body and mind, but to give full attention to those aspects of embodiment that are not amenable to fashioning by the ‘thinking mind’.

It is perhaps also helpful to say briefly here what this thesis is not. It is not a study about whether CAM works or not, although this is clearly a popular topic in

much of the research today into CAM. It is about how knowledge of the body in health and illness can be constructed, re/produced and positioned in relation to dominant ideas about socially valued work, and about how the development of knowledge and skills are managed by student practitioners and how this process shapes their own embodied identities. In addition, it is not the intention of this thesis to compare these students' experience with that of medical students. Clearly, however, there is potential for comparisons to be drawn at a later date. The thesis instead seeks to explore two main substantive areas: (i) the ways in which knowledge about health and healing is re/produced by alternative medical communities, and the form and structure of that knowledge in theory and practice, and (ii) the ways that students negotiate the learning process and the extent to which this shapes or changes their embodiment.

Chapter One provides an introduction to the intellectual context in which research on the training of CAM practitioners can be located, and identifies the 'gaps' relating to the practice of CAM. In particular, this chapter aims to justify the application of an 'embodied' sociology to a subject that cuts across the substantive areas of health and healing, work and employment, the professions and education. It provides an overview of the historical and contemporary position of CAM, concentrating on osteopathy and homeopathy where possible. It then goes on to address literature relating to knowledge and power in medical practice, examining the extent to which the role of CAM in the social organisation of healthcare practice has thus far been addressed. After arguing that research on the training of CAM practitioners offers a unique and worthwhile subject for exploring some of the issues raised, the chapter turns to current literature on the training of healthcare professionals, and highlights the contributions of embodied sociology. The chapter

turns finally to building a theoretical framework for the development of the research and analysis of my findings, drawing particularly on the approach of Pierre Bourdieu and feminist interpretations of his work.

Chapter Two gives an account of the research from its inception as an idea to its completion as a written thesis. By exploring three cross-cutting and non-linear aspects of the research process – motivation, immersion and expression – the chapter draws out the conceptual links between theory, practice and ethics in ethnographic research, as well as shedding light on the direction that the study took and the claims to validity of the findings. The discussion includes a justification of the application of ethnographic research methods and an explanation of the choice of the two case studies – the anonymized Colleges of Osteopathy and Homeopathy. It tackles ethical issues, such as exploitation and consent in field relations; practical issues, such as access, and issues related to becoming familiar with the setting, including developing practical sense and reflexivity. Finally, it addresses the process of analysis and writing, and the significance that these have for the experience and outcomes of doing research. My own embodiment in the settings and research process is a constant theme throughout this chapter (and indeed the thesis as a whole) and pertains to the biggest challenge I found in a research setting that demanded a high level of participation, which was to avoid ‘going native’. In this chapter, I offer personal reflection on my motivations for the research and my experiences during the process.

Chapter Three offers a descriptive sketch of the research field to give the reader an opportunity to get a ‘feel’ for both the historical and political background that helps shape the current professions and the physical environment and the organisational structure of the colleges. It also details the curriculum and the teaching methods used in the colleges, which sets the scene for the experiences of the students.

While the structure of the course and the characteristics of the staff are inevitably somewhat fixed, students are not passive actors in the educational environment.

Chapter Four seeks to explore the ways in which the students negotiate their course of study and come to value and certain knowledge, skills and ways of being-in-the-world. First, it introduces the students and emphasizes that the students are not ‘blank slates’ as they enter the college environment. As students are self-selected into the profession, it may be that their capabilities and preferences for certain ways of knowing and being are already embedded to a certain extent. Then, taking each profession in turn, the chapter explores the student responses to the staging of the curriculum, the ways of learning and the modes of assessment. It demonstrates that learning is not simply about learning new patterns of thought, but involves a fundamental change in embodiment that is unique to each student.

Chapter Five explores the students’ experience of learning the ‘theory’ about the healing process. Focusing on classroom teaching and learning, the chapter investigates the kind of bodies that are envisaged on both sides of the therapeutic encounter. Because it avoids many of the uncertainties of clinical practice, the classroom teaching tends to reproduce ‘ideal’ models of the healing process, and the practitioner’s role in this. The chapter examines the knowledge and skills that students acquire both in relation to getting information from the patient about his or her condition (what I term ‘listening to body-talk’) and the process of analysis and treatment of the case (what I term ‘developing body-stories’). The students’ own bodies are heavily implicated in the learning of these professional skills.

Chapter Six turns to the students’ experience of working with ‘real’ patients. It seeks to disentangle the three-way power relationship in the student clinics – between tutor, student-practitioner and patient – and to establish the implications that

the learning experience has for the embodiment of the students, their negotiation of the course, and their future practice. In particular, the chapter asks what sort of patient and practitioner bodies the clinical experience produces, whether it is possible to say that students produce a ‘osteopathic habitus’ or a ‘homeopathic habitus’, and, if so, what the nature of that habitus is.

The final chapter draws together themes that have emerged during the discussion of the findings of the research, evaluating the contributions to sociological knowledge made by the thesis and identifying areas for future research.

Finally, before we turn to the first chapter, a note on terminology. As Chapter One explains, there is continuing debate within and between healthcare professions about the appropriateness of terms such as ‘holistic’, ‘natural’, ‘alternative’ and ‘complementary’ to describe a diverse group of healthcare practices. For clarity and consistency, I will use the generic, and currently popular, term ‘CAM’ as a descriptor, or use the term non-orthodox medicine when I wish to stress the social relationship to the orthodox medical profession. In addition, I will use the terms practitioner and patient, first, to distinguish their interaction from the orthodox medical ‘doctor’-patient relationship; second, to specify the unique nature of the contractual relationship in health care practice, as opposed to ‘client’ or ‘customer’, and third, because they were the terms most frequently used in the research field.

ONE

Health care, education and embodiment: a review of the literature

Introduction

Research on and analysis of the training of osteopaths and homeopaths potentially provides insights into a range of areas relevant to sociology and social policy. This chapter seeks to conceptually locate this ethnography in the contemporary sociological literature, and define the areas to which it intends to contribute. In particular, the chapter aims to justify the application of an ‘embodied’ sociology to a research topic that cuts across the substantive areas of health and healing, the professions, work and education. The chapter explores why CAM training might be a useful empirical subject for an ‘embodied sociology’ and, vice versa, why embodied sociology is a potentially productive theoretical approach to use to understand CAM training. In order to do this, the chapter addresses three key interrelated questions: (a) what does the existing literature tell us about the social organisation of CAM practice? (b) what kinds of sociological debates are relevant for research on the training of healthcare professionals? and (c) what theoretical frameworks might be suitable for the development of the research?

I want to argue that research on the training of CAM practitioners can potentially make a valuable contribution to the discipline of sociology, both as a substantive empirical area that remains under-researched, and as a tool for exploring

the relevance of the 'body' to the sociological endeavour. To this end, I will review and appraise the literature relating to the rise of CAM in the contemporary organisation of health care, concentrating on homeopathy and osteopathy where possible; the historical and contemporary relationship between CAM and orthodox medicine, and debates around power and knowledge in different forms of health care. I will consider the contribution and challenge offered by embodied sociology to these debates, and clarify why CAM training offers a unique and worthwhile subject for the exploration of many of these issues. I will go on to review aspects of the current body of literature relating to the training of healthcare professionals, including debates on the development of professional identity, the value assigned to different knowledge and skills, and students' experiences. Although the literature on the training of CAM practitioners is extremely limited, some studies offer a valuable starting point for engaging with the subject. Finally, I will cast a wider net over the sociological literature, to begin to think about ways in which it may be possible to explore and conceptualize the experience of student osteopaths and homeopaths. Some current theoretical debates on embodiment and the body in society are reviewed and assessed for their potential usefulness as theoretical tools for the research.

The training of CAM practitioners: an unexplored subject for embodied sociology

As an academic discipline, sociology has a responsibility to be responsive to the developments in the society that it serves. For this reason alone, the rapidly increasing popularity of non-orthodox approaches to health care, and the training of those practitioners, deserves the critical eye of the sociologist. The cultural and

professional dominance of biomedicine has received a great deal of academic attention, and indeed

for Bourdieu, the point of sociology is not to gather information about how society is organised, but to critique the discourses and practices that stand for us as ‘truths’. He sees sociology as dealing with a philosophical and a political, rather than a scientific, problem’ (Webb et al., 2002: 66).

By contrast CAM has received much less academic attention. Yet many CAM practices claim to offer a fundamental philosophical and epistemological alternative to biomedicine, and their rise may indicate a simmering discontent with the lack of diversity or flexibility in the delivery of health care. Yet many of these CAM therapies have received a great deal of ‘bad press’, accused of being scientifically unsound and opportunist in the face of vulnerable patients. In approaching a topic such as this, our responsibility as sociologists is to keep an open mind and a reflective attitude, while remaining critical of what we find, thereby applying our ‘sociological gaze’ to the subject.

It is important to be wary of caricaturing either biomedicine or CAM. Boundaries between orthodox and alternative medicine are not as stable or impermeable as either social scientists or practitioners from either ‘side’ have generally made them out to be (Cant & Sharma, 1999: 186). There is clearly diversity of practice under the banner of CAM, as there is a multiplicity of therapies, many of which have vastly different ontological, epistemological and cultural bases; the biomedical model, however, is also only an ‘ideal type’ representation of ‘modern’ or ‘scientific’ medicine, a foundation for the day-to-day practice of those working in heterogeneous ways within the orthodox health-care professions.

There are three main areas of the critical literature in the sociology of health and illness that can help elucidate the contemporary rise of CAM and set the context for a study on the training of CAM practitioners: the historical and contemporary relationship between orthodox and non-orthodox health professions, the exercise of medical power at the macro- and micro-levels, and the nature of medical knowledge. The review will consider the contribution of embodied sociology to these debates where applicable, and highlight areas to which research on the training of CAM practitioners can contribute.

Professional rivalries: orthodox and non-orthodox medicine

First, it is important to understand CAM as a socially located practice in relation to the dominant medical paradigm. Historically, the relationship between the medical profession and alternative practices, such as osteopathy and homeopathy, has been characterized by animosity. Most historical and sociological studies have considered professional (Nicholls, 1988; Saks, 1995; Weatherall, 1996) and industry (Walker, 1994) self-interest as a key explanatory factor for this animosity, and detail the 'tactics' used by the orthodox profession to protect their status and livelihoods. While it is possible to note some similarities with the exclusionary treatment of non-professional healers, particularly women, in earlier centuries (e.g. Ehrenreich & English, 1973), accusations of links with the Devil and dangerous female sexuality could not be used against what, in the nineteenth century and much of the twentieth century, were almost exclusively male professions, and usually practised by men who were qualified medical doctors. In addition, osteopathy and homeopathy were both developed in Western countries, the United States and Germany respectively, by

white, male, qualified medical physicians. (The origins of osteopathy and homeopathy will be explored in more detail in Chapter Three.)

When it was introduced to the UK, homeopathy quickly gained a minority following within the orthodox profession, and one with some clout, as even the Royal family became committed to using homeopathic remedies. Nicholls (1988; 1992) argues that the British medical profession began quickly to perceive a financial threat from those colleagues who began to practise homeopathy and were being very effective while using much more gentle therapeutic techniques than the orthodox medical ones popular at the time. Exclusionary tactics for those doctors practising homeopathy were often directed at educational institutions, which were seen as the future of the medical profession. Homeopathic doctors were excluded from professional organisations, unable to publish journal articles and forbidden from teaching at medical schools (Weatherall, 1996). However, while officially homeopathy was subject to theoretical rubbishing, Nicholls (1992) argues that the medical profession assimilated elements of homeopathy, such as low dosage and the 'law of similars' without recognition of their homeopathic source. He concludes that it was this combined strategy that was such an effective check on homeopathy's growth at that time because homeopathy lacked the cultural gravity of the orthodoxy, and so homeopaths were unable to expand their practices any further. Additionally, industrial interests have also played an important role in the direction of growth of the medical profession. The pharmaceutical industry has an evident vested interest in the widespread use of standardized and profitable medicines, and it has supported scientific medicine through funding pharmacology and research departments (Walker, 1994).

Nevertheless, there has been an explosion of popularity and public exposure of many CAM therapies, especially since the 1970s. In 1986 the British Medical Association published a report widely condemning non-orthodox practices as without scientific basis and their practitioners are charlatans and ‘quacks’ who dupe people into handing over money for ineffectual treatment (BMA, 1986). However, this did not stop the growth of these practices, and seven years later the BMA changed tack completely, scrapping the term ‘alternative’ and introducing ‘complementary medicine’ (BMA, 1993). Cant and Sharma (1999) argue that this move was motivated by widespread criticism that the BMA was being dogmatic by rejecting non-orthodox approaches completely, so they sought to redefine their role as an ‘arbiter’ of ‘good’ and ‘bad’ medicine. This constituted ‘a shift from the celebration of the *cognitive* authority of medicine as a form of scientific knowledge to a celebration of its *moral* authority to protect the consumer by pronouncing standards of competence’ (Cant & Sharma, 1999: 104). It may be that the potential loss of moral authority is the biggest concern for the orthodox medical profession, which has been further threatened by various social movements, such as the self-help, hospice and women’s health movements; the increasing threat of litigation, and widespread social criticism of the safety of drugs and the professionalism of doctors, particularly highlighted in the press by controversies such as Alder Hey and the murders by Dr Harold Shipman.

Despite these historical and contemporary antagonisms, there has been an enormous boom in demand in recent years for CAM in the UK and elsewhere. An April 2001 survey by the Office for National Statistics found that one person in ten in the United Kingdom had used a complementary therapy in the previous 12 months. A survey of voluntary regulatory bodies for complementary therapies, commissioned by

the Department of Health and published in 2000, indicated that there were then around 50,000 CAM practitioners in the UK. The survey further indicated that almost 10,000 orthodox healthcare professionals were practising CAM of some kind. Saks has argued that there have been 'recent signs of some kind of *rapprochement* between orthodox and alternative medicine' (2003: 154). Cant and Sharma (1999) have argued that there exists the beginnings of a 'new medical pluralism', while recognising that hierarchical relations remain.

The British Medical Journal has published a number of articles and editorials about CAM, often focused around questions of effectiveness (e.g. Mason et al., 2005) or regulation (e.g. Mills, 2005). However, there have also been calls for a more serious attempt to investigate issues of the cost effectiveness of CAM within the NHS (Thompson & Feder, 2005). Additionally, there has been some discussion of the potential benefits of including teaching on CAM in the medical education curriculum to encourage students to develop a more holistic view of health care (Berman, 2005). There have been a few sociological studies on attempts at collaboration between doctors and alternative therapists (Budd et al., 1990; Peters, 1994; Sharma, 2002). These and other studies have identified potential problems with integration such as ideological dominance, problems of incongruent use of language, referral problems, and resource allocation. Nonetheless, the idea of 'integrated medicine' has become popularized and is put into practice particularly in multi-disciplinary pain clinics and organisations such as the Bristol Cancer Care Centre (see also Prince of Wales' Initiative on Integrated Medicine, 1997).

In addition, in the political climate today, many CAM practitioners have begun to take steps to regulate their profession, setting up professional associations that specify required training, publish registered practitioner lists, and organize

continued education through seminars and conferences. Osteopathy is now a legally registered profession (Osteopaths Act, 1993), although the debate remains alive within osteopathy as to the extent that the regulatory process has compromised the core beliefs of osteopathy. In 1996, Cant and Sharma gave an account of the 'professional project' in homoeopathy, which had involved changes in the way knowledge is constructed and communicated in order to develop claims for legitimacy, status and authority, although they noted that the process had been far from clear or straightforward. Issues such as different groups within homeopathy having varying priorities, uncertain boundaries around homeopathic remedy usage, complex attitudes to the usefulness and validity of scientific testing, and problems with setting up referral systems had all contributed to the picture. Today, the Council for Organisations Registering Homeopaths (CORH) is working towards a 'single register' for homeopaths and is tackling head on some of these complexities¹. Cant and Sharma identify a paradox that 'postmodern diversification of knowledge is occurring', yet 'the ways in which the knowledge of the various groups has been publicly transformed tends to suggest that modernist and orthodox standards have been called upon'. This, they argue, has the 'effect of marginalizing complementary medical groups in that they have lost some of their individuality and have accepted positions subordinate to biomedicine' (1999: 80-81). In this dynamic context, the education and training of practitioners is at the centre of many debates about the future of these professions.

¹ As a result of this research, I have attended some of the meetings of CORH, and have been involved in the Accreditation Working Group, which is developing an accreditation process and criteria for homeopathic course providers.

Patients are choosing, in significant numbers, to seek advice and treatment from CAM practitioners. This has a potentially disruptive effect on the doctor-patient relationship, at least as it is envisaged by Parsons (1951) and other functionalists. They see the role of medicine as crucial to the successful functioning of our society, through the minimization of sickness, and the designation of an acceptable 'sick role' that requires the sick individual, with the guidance of medical professionals, to do everything possible to return to 'normal' social functioning. However, many other approaches are more critical of the effects of medical dominance, at both a macro- and micro-level. Some commentators have suggested that CAM offers the individual patient greater control over his or her illness experience as well as challenging medical power at a macro-level. However, these claims have not remain unchallenged.

Critiques of medical power at a macro-level have come from a number of quarters: for instance, from a Marxist perspective, the imperative of capital accumulation can be seen to be functionally related to the inequalities of the modern Western healthcare system, by ensuring people are fit for work, while failing to tackle the underlying social causes of health inequality (Navarro, 1976). A key debate in contemporary sociology has been the nature and extent of medicalization, which arose initially from Marxist perspectives and the liberal humanism of the social movements of the 1960s and 1970s (Lupton, 1997). Critics such as Friedson (1970) and Zola (1972) argue that due to the arrogant belief in medical efficacy, 'medical imperialism' has come to dominate all areas of social life, especially those traditionally performed by religion and the law. However, these approaches tend to deny agency to

individuals, such as those who strive to have certain health problems defined as medical, as in the cases of ME (Myalgic Encephalopathy), CFS (Chronic Fatigue Syndrome) and RSI (Repetitive Strain Injury). Lupton suggests that a Foucauldian approach has more explanatory potential: 'Rather than there being a struggle for power between the dominant party (doctors) and the less powerful party (patients), there is collusion between the two to reproduce medical dominance' (1997: 98).

While the early work of Foucault was primarily concerned with the exercise of 'bio-power' and the production of 'docile bodies' (Foucault, 1984), Lupton argues that Foucault's later works move away from the image of 'docile' bodies being operated on by powerful discourses towards the idea of self-discipline through technologies or practices of the self. This focused on 'the interrelationship between the imperatives of bodily management expressed at the institutional level and ways that individuals engage in the conduct of everyday life' (Lupton, 1995: 103).

Feminist literature has often focused, at the micro-political level, on the role of the patient-practitioner relationship in the playing out of medical power on the female body, through the admonition from the medical profession that 'doctor knows best' (Oakley, 1980). The construction of active-passive roles in the doctor-patient relationship, is underpinned by the medical classification of reported *symptoms* as 'subjective' and *signs* observed by the doctor as 'objective'. This, Mishler (1990) argues, leads to patients being systematically 'ignored' and 'interrupted' in the medical interview. In this framework, the doctor is the active party in the medical process, the 'hero' in the medical story. This is reinforced by the use of 'war' metaphors in medicine, that locate the disease as an 'other than self' entity that must be fought against (Hodgkin, 1985). The power relations in medicine, where the

patient is perceived as a passive recipient of health care, serve to further entrench gender and racial inequalities (e.g. Ahmad, 1993; Doyal, 1995).

Within the medical profession, developments such as Balint's (1957) concept of 'doctor as drug' have explored the importance of developing a good relationship with patients, and its influence on general practice is undeniable. However, using Foucauldian analysis, Gothill and Armstrong argue that:

the new clinical approach [post-Balint] shared the basic medical premise that there was an objective reality called 'the patient', which should be examined objectively in order to devise and apply rational methods of treatment. The difference was the replacement of the language of anatomy and physiology by that of biography and psychology, in a way that actually tended to preserve the medical paradigm in the face of a changing world (1999: 6).

Nevertheless, the vexed medical debate on how to achieve 'patient compliance' (e.g. Conrad, 1985; Trostle, 1988) both illustrates the way that the doctor's role as expert is deeply embedded in medical discourse, and that, in practice, doctors and other medical professionals are far from being able to achieve complete dominance or 'compliance' with their approach. Although this creates day-to-day ethical challenges for medical staff who 'worry over how ethically to handle incompetent, non-compliant, or self-destructive patients' (Chambliss, 1996: 149), there is mounting pressure on doctors to engage with their patients in a more co-operative manner, and evidence to suggest that this message is getting through to some extent with positive results (Pietroni et al., 2003). The suggested introduction of the concept of 'concordance' to replace 'compliance' is illustrative of these changes (Royal Pharmaceutical Society of Great Britain, 1997).

It has been suggested that the practice of CAM therapies offers a challenge to medical power both at the micro-level and at a societal level. Turning first to the micro-level, using CAM could be, for individual patients, a means of resisting medical control and invasion of their bodies. Investigating the reasons for the popularity of CAM, Sharma (1990) concluded that there were 'negative' reasons against using orthodox medicine and 'positive' reasons for using alternatives. The key 'negative' themes were that conventional medicine fails to get to the 'root cause' of chronic illness; fear of drugs that could be habit-forming or have unpleasant side-effects; dislike of radical and invasive treatments; the perceived inability of conventional medicine to deal with the social and experiential aspects of illness, and dissatisfaction with the doctor-patient relationship. The key 'positive' themes were that patients received recommendations through word-of-mouth about particular practitioners or therapies, and that people would experiment with new therapies, either through desperation or as a result of previous positive experiences. Ideological commitment was cited by her participants mostly as a reason for the *continuation* of treatment rather than the initial resort to it. Sharma concluded, however, that the most important positive reason that CAM users cited was 'a conscious appreciation of the more active role they felt able to play in the management of their illness or the general pursuit of health' (Sharma, 1990: 40).

In CAM, a 'partnership' model of interaction between patients and healthcare professionals is generally promoted: 'the giving and receiving of health care as a negotiation agreed between the parties' (Hogg, 1999: 46). There should be a joint assessment of goals, and the patients retain rights and responsibilities for their own health. Sharma (1994) argues that CAM practitioners tend to deny that control in the therapeutic encounter is the product of a zero-sum game:

The ideal which they [CAM practitioners] hold to is one in which patients initially seek some form of help which they cannot provide for themselves, draw on the healer's expertise, then gradually become more independent and self-reliant with respect to their health and well-being (Sharma, 1994: 91).

Hogg, however, suggests that 'the patient as partner' is a modern myth, because as compared to practitioners, 'patients have much more to win and much more to lose: the type of health care they receive may be a matter of life or death' (Hogg, 1999: 171). Although she is referring primarily to the possibility of partnerships with government, medical professionals and pharmaceutical companies, she raises the important point that the partnership model can not account for genuine conflicts of interest. From another perspective, Coward warns that this model of joint responsibility for the healing process can lead to 'victim-blaming': 'the possibility that an individual has control over health and the possibility that an individual can be blamed for disease often shade into one another' (1989: 69).

At a macro-level, the energy that the orthodox profession and the pharmaceutical industry have put into bringing CAM therapies and their practitioners into disrepute certainly suggests that they perceive them to be a significant threat. Ostensibly, this is to protect vulnerable patients. However, in their study of health beliefs of patients visiting different healthcare practitioners, Furnham and Smith concluded that 'contrary to expectations, "blind faith" in the efficacy of treatment is not the view held by the alternative homeopathic patients, but instead by the GP patients and their belief in conventional medicine' (1988: 688). McKee (1988) argues that CAM offers a challenge to the dominant medical system because it does not promote the production of highly profitable standardized drugs, and its growth could,

therefore, potentially threaten the monopolistic position of medical doctors, drug companies and other agents of the medical industry.

However, involvement in the healing process does not necessarily imply a political challenge. As Wolkowitz points out, albeit in an employment context, ‘agency is not the same thing as resistance’ (2006: 21). Indeed, some argue that far from being a challenge to the dominant biomedical system, CAM seeks only to effect personal transformation. For example, Coward proposes the concept of the ‘wholesome entrepreneur’ to describe users of CAM: ‘the perfect resolution of a personal politics of the body with a peaceful co-existence within the existing economic structure’ (1989: 204).

On the other hand, some have argued that the ‘personal’ of the inner journey can be ‘political’. Scott (1998a) offers one of the most considered discussions of this, on the question of whether homeopathy can be considered a feminist form of medicine. Her research with self-identified ‘feminist homeopaths’ showed that many practitioners aimed specifically to help raise the physical and emotional health and strength of their patients to a degree that they felt able to challenge those social conditions that harm them. This, she argues, alongside other forms of social activism such as community health campaigns, anti-vaccination campaigns, the development of free or low-cost clinics and charity work at home and abroad can be seen as a form of ‘progressive individualism’ (Scott, 1998a: 193, 200). Proponents of CAM argue that the patient-practitioner relationship is more egalitarian than that in orthodox medicine, and so represents a challenge to the orthodox model of healing. Certainly, there is significantly less division of labour in the therapeutic process. The patient is almost always in a one-to-one relationship with the practitioner (although busy practitioners or groups of practitioners may employ a receptionist or cleaner), and

patients can discontinue treatment at any time. Sointu argues that key to the therapeutic relationship in CAM is 'recognition': 'different levels of recognition that pertain to affirming the self, as well as to legitimizing identities and complaints, often come together to endow the client with a sense of both empowerment and control' (2006: 507).

However, this empowerment and control may be illusory because, under a 'holistic' medical gaze, every element of a person's mind, body, spirit, lifestyle and environment are seen as valid areas for enquiry. Scott argues that in homeopathic treatment, the patient's perspective and role in healing is vital and valued, yet the prescription may challenge social problems in a woman's life that she may have had no conscious understanding of at the time of treatment; homeopathic prescribing, she warns, 'opens the door to a normative power which, potentially, far exceeds that held by the biomedical practitioners criticized by female health activists' (1998a: 210).

Drawing on Foucault, Braathen suggests that,

It would not be too far-fetched to suggest that homeopathic discourse constructs a new kind of medicalization through 'healthization' of life, as every aspect of the patient's life is of interest in establishing a complete symptom picture. This might be termed a new form of surveillance of life-worlds where the homeopath, in contrast to the epidemiologically informed medico-social survey as an important device in the disciplining of populations, has become an important agent in carrying into effect self-disciplining technologies (1996: 157).

However, Lowenberg and Davis conclude that the balance between empowerment and medical control is complex:

The denial to patients of the privilege to be absolved from responsibility for their illnesses smacks strongly of demedicalization, while the application of a health-illness paradigm to

nearly every domain of life represents, if anything, a massive thrust in the direction of medicalization (1994: 584).

Certainly, the dismissal of CAM practitioners as ‘charismatic healers’ who deny the value of the patient’s input or as deceptive ‘quacks’ who may take advantage of vulnerable people seems premature and reactionary. However, with the notable exceptions mentioned above, there is still very scant research addressing and debating these issues. Many discussions are either too general, failing to acknowledge the variety of practices under the CAM banner, or limited by a superficial understanding of the therapies in question. It is clear that the therapeutic relationship is complex, culturally- and socially-bound, and inextricably linked to questions of patient-practitioner power relations. There is a great need for a deeper analysis of the ways in which patients and practitioners (learn to) negotiate their roles, responsibilities and the dilemmas of power in the CAM therapeutic encounter.

Medical knowledge and the body

Questions about the validity, reliability and social meaning of different forms of knowledge about health, healing and the body are vital to debates about CAM. The object of most orthodox medical knowledge is the human body, and so understandably debates on medical knowledge often overlap with the debates on medical power and control of bodies discussed above. It is often argued that CAM therapies are based on fundamentally different ontological and epistemological principles; however, the extent to which non-orthodox approaches offer a real alternative to medical knowledge remains uncertain. Indeed, the diversity in terminology – non-orthodox, alternative, complementary, holistic, natural, traditional

– is indicative of the complexity and the confusion about what exactly different approaches can offer. There are clearly disjunctions between biomedicine and the various non-orthodox approaches, and a great deal of work is done by each ‘side’ legitimizing their own approach and criticizing the other. These disputes often centre on what constitutes valid knowledge about the body and what ‘works’ in the treatment of disease, and have significant implications for a study on practitioner education. Sociologists of science have problematized the terms of these kinds of questions, while feminists and sociologists of health and illness have tended to focus on the social meaning of different ways of knowing the body. While critiques of medical knowledge are well-developed, there is much less literature on the knowledge bases of CAM approaches to health and the body.

Many of the debates between orthodox and non-orthodox professional groups have centred on an allegiance to either ‘science’ or ‘holism’. Proponents of biomedicine have sought to condemn non-orthodox practices as being ‘unscientific’: at best, ineffective and, at worst, dangerous. On the other hand, proponents of CAM have espoused their ‘holistic’ credentials, rejecting biomedicine, or ‘allopathy’, as a crude and reductionist way of dealing with an ill patient (e.g. Dethlefsen & Dahlke, 1990; Page, 1992). In addition, many have drawn on the language of iatrogenesis (Illich, 1976) and medicalization to condemn allopathy as a dangerous and disrespectful practice (Leboyer, 1975; McTaggart, 1996; Odent, 1976). Nevertheless, some CAM groups have also sought to defend their practices as scientifically valid, though debate in professional and academic journals, such as the *British Homeopathic Journal*, the *Journal of Osteopathic Education* and the *Journal of Alternative and Complementary Medicine*; research into the nature of the so-called ‘placebo’ effect in

complementary medicines (Peters, 2001), as well other theoretical (Rubik, 1994; Walach et al., 2005), and empirical (e.g. Taylor et al., 2000) scientific studies.

The simplistic differentiation of science and non-science has been criticized widely by sociologists who have demonstrated that the production of knowledge is always deeply embedded in social context (Fuller, 1997; Kuhn, 1962). Additionally, the apparent ‘certainty’ of scientific knowledge has been shown to be an inadequate way of conceptualizing medical knowledge (Fox, 2002), not least because of the cultural division between the ‘bench’ and the ‘bedside’ in medicine. In a further complexity in the terms of this debate, while holism has become a ‘buzz word’ of the alternative health movement, as a principle it had also been adopted by orthodox medicine, especially in general practice and health promotion. Armstrong (1986) argues that far from being a new trend or even a rediscovery of the ‘whole person’ in medicine, holism represents a continuity with the past in that it continues to construe the patient in terms of an independent subjective patient identity. This, he argues, is a universal concept that medicine continues to claim jurisdiction over. While clearly many CAM therapies are based on fundamentally different epistemological and/or cultural principles to biomedicine, and it would seem necessary to conduct work on individual therapies before jumping to any conclusions.

Embodied sociology has explored the significance in practice of the ‘body’ as the object of medical knowledge. In many embodied approaches, including feminist ones, medical discourse is seen to reproduce Cartesian mind-body dualism. For instance, the body in orthodox medical discourse is often represented as a ‘battleground’ which, Stacey argues, promotes

masculine hero narratives of science... Trust the doctors, they know best. Your body becomes the battleground between good science and bad disease. If you give yourself up to their wisdom and follow their instructions you stand the best chance (1997: 11).

Most feminists argue that dualisms are gendered and the 'body' and the 'feminine' become devalued. For example, according to Wilshire,

The history of western civilisation and philosophy is varied to the extent that each era stresses its favoured, characteristic aspect of knowledge and its acquisition, but each era in this history has in common with each other era *the explicit devaluing of earth and body* – most especially the female body along with female-associated ways of knowledge and being-in-the-world (1989: 94).

In addition, in orthodox medical discourse patient identity is often reduced to the part of the body that is 'malfunctioning', creating a conceptual separation of mind from (part of) body. As Stacey notes, 'Doctors' metonymic references to patients as their illnesses ('This is the teratoma I told you about') reduces the patient's identity to a set of physical symptoms and alienates them from the medical process' (1997: 107).

While these observations obviously have implications for power relations in the therapeutic encounter, they are also vital for setting the context for understanding how different ways of knowing might be valued in the training of CAM practitioners.

The position of the body in medical knowledge/power systems is often claimed to contrast with the 'holistic' principles of CAM therapies, which often view the body as intelligent. For instance, according to Kern, a cranial osteopath,

nature is supremely intelligent and does not make mistakes. Nature always seeks balance, whatever the circumstances. This is not an idea born out of some act of faith, but something

that can be seen operating throughout creation. The way the world turns, a forest regenerated or a wound heals are examples of this (2001: 90).

Clearly, the existence of an ‘intelligent’ body would have implications for medical epistemology. In addition, principles of ‘holism’, which stress that the human is irreducible to component parts, stress that in the construction of medical knowledge it is extremely problematic to separate mind, body, emotions, and the spiritual, and that each individual can only be understood in relation to his or her social and physical environment. Indeed, ‘disease’ is often hyphenated (‘dis-ease’) by CAM practitioners to emphasize the mental and emotional aspects of illness. This raises questions about what knowledge and skills would be useful for a practitioner. Fact-based academic learning may be only one appropriate form of knowledge, alongside practical embodied skills, emotional skills and the development of intuition and reflective capabilities.

Yet, while debates about the safety, validity and effectiveness of medical interventions are highly developed both within (e.g. evidence-based medicine) and outside (e.g. Illich, 1976; McKeown, 1976) the medical profession, discussions of the effectiveness of non-orthodox approaches never seem to get past the ‘accusation’ that any therapeutic action is simply due to the ‘placebo’ effect. Randomized Controlled Trials (RCTs) seek to identify the effectiveness of single interventions, and have long been recognised as inappropriate for the assessment of multi-dimensional interventions, in health promotion for example. For this reason, the applicability of RCTs to ‘holistic’ therapies has been questioned (e.g. Milgrom, 2005).

It is important to note that many CAM practitioners choose to bypass this debate about science altogether, and establish their legitimacy through ‘non-scientific’ concepts and belief systems. These may be related to cultural and religious systems,

such as Ayurveda and Chinese Medicine, or to spiritual systems such as the Chakra system, or the Shamanic elemental system. In addition, in CAM there are significantly more female practitioners, and many women's health movements and feminist healthcare practitioners have embraced alternative health care. From the historical practice of midwives, herbalists, witches and shamans (Oakley, 1992; Tedlock, 2005), women have often performed a healing role in communities, engaging in practices that have often been 'written out' of history by male anthropologists and medical professionals, or made illegal through the Witchcraft laws in Britain. Many feminist practitioners of contemporary alternative medicines invoke this historical link in their professional identity and claims to valid knowledge. It would not be possible to try and do justice to any of these concepts or healthcare systems here, but it is significant that from the point of view of CAM communities, scientific proof is not always considered important because it is not considered the most effective or legitimate way to understand the human body and dis-ease. This also acts as a powerful defence mechanism within CAM communities to avoid feeling invalidated by the criticisms from outsiders.

Sociological studies on the 'body' in non-orthodox medicine illustrate its ambiguous, not-as-object position in the therapeutic encounter. Scott's various articles on homeopathy (1997; 1998a; 1998b; 1999; 2003) explore the body in homeopathic practice. She argues that homeopathy is a form of partially embodied social discourse. Her research with feminist homoeopaths highlighted the potential for homeopathic remedies to become a 'site for contestation regarding the connection of bodily, emotional and mental "symptoms" with social positioning and material life experiences' (Scott, 1998a: 201). She demonstrates that the scope for incorporation of extra-physical factors in prescription is not merely an add-on but deeply embedded

in the structure of the therapy. Sharma argues that the ‘body’ in homeopathy is not an ‘object’ that can be read or ‘penetrated’ by the gaze of the practitioner. The body is a phenomenological entity, characterized by symptoms or ‘tendencies’, that can not be represented through ‘static graphics’:

Symptoms, therefore, can only be interpreted in as much as they can be identified in terms of time sequences. They can not be interpreted outside the framework of the homeopathic history of the patient. An actual aggravation of some old symptoms may herald the start of progress towards health (Sharma, 1995: 39).

More generally in the sociological literature, research into embodiment in the healing process has problematized the view of the body as an static object of medical knowledge. For instance, writers such as Bury (2001), Frank (1995) and Hyden (1997) have explored different narratives in healthcare settings and explored the temporal interaction of the body with its environment. In addition, the health effects of the social environment has been long acknowledged in the social sciences and public policy (e.g. Marmot & Wilkinson, 1999). The complex relationship between the body-self and its environment has implications for the ways it is possible to ‘know’ or ‘treat’ the sick body. And here, we return, full circle, to the debates about the patient-practitioner relationship and power, control and responsibility in the healing process. Research on the training of CAM practitioners can hopefully shed light on some of these debates, by examining what might be distinct about the roles and responsibilities of patient and practitioners in the therapeutic encounter, and what knowledge and skills are seen as valuable for student-practitioners to learn.

In conclusion, CAM training might be a useful subject for an ‘embodied’ sociology, because it offers potential insights into an under-researched substantive area and, because of the explicit focus on ‘the body’ in healthcare work, it offers a unique site for exploring the relevance of embodiment to sociology. While the sociology of health and illness provides an understandable home for those interested in embodiment, the ‘sick bodies’ on which (orthodox) healthcare work is performed paint only a partial picture. The consultation is interactional, and skilful practitioners are able to negotiate their own (precarious) embodiment in the therapeutic relationship. Many questions remain unanswered about the play of power, knowledge and the body in the practice of non-orthodox forms of medicine. The educational environment offers a potentially fruitful site to access the kinds of assumptions and beliefs that underpin the day-to-day practice of CAM, as many of these issues are tackled head on by students learning to *be* practitioners. I now go on to review the sociological and professional literature on the training of health-care practitioners.

Educating health professionals: research and debates

Although there is very little sociological research on the training of CAM practitioners, there is significantly more literature relating to training and education in the health professions more generally. Here, I explore contemporary debates relating to the learning and development of the necessary skills for healthcare practice, and how different forms of knowledge (ways-of-knowing) are valued in the educational environment, and inculcated by the students. I then go on to explore accounts of the development of professional identity, including commitment to the profession, and

find that there are few accounts of the implications that this educational experience has for the embodiment of the student.

Developing professional knowledge and skills

Examining the structure and content of different curricula can be revealing about how ‘legitimate’ knowledge is constructed by educators. Changing policies and practice in the training of medical doctors have been seen as a response to some of the critiques of the medical profession, discussed above, especially those about the doctor-patient relationship. In addition, challenges from nursing and other healthcare professions demonstrate resistance to both the traditional values placed on ‘academic’ knowledge and the associated symbolic violence against those who do not conform. There is very little research on the training of CAM practitioners, but some work on the professionalizing process has highlighted the centrality of the ‘knowledge’ question in relation to professional legitimacy.

Traditionally, medical educators have focused on academic learning of anatomy and physiology in the early years, only later introducing the student to ‘real’ clinical situations. The ‘clinical experience’ marks a significant turning point in ‘any doctor’s individual, professional biography’ (Atkinson, 1981: 2), because of the centrality of the clinical tradition to the culture of medicine (Foucault, 1963).

However, the dominance of the medical model over the illness experience is already part of the wider cultural competency of the student doctor and the clinical experience may actually only serve to reinforce hierarchical interpersonal dynamics through role-playing and clinical training. In addition, knowledge hierarchies can impact on the ‘learners’ as well as the patients, and Belenky et al. (1997) argue that (gendered)

knowledge hierarchies are particularly evident in educational practice. The dominance of modernist and rationalist educational strategies have been particularly criticized by feminist researchers for being insensitive to the experiences of women learners.

In recent years, following the publication of the GMC (1993) report *Tomorrow's Doctors: Recommendations on Undergraduate Medical Education*, changes have been made in doctors' training. The report proposed that medical students should, from the beginning of their training, work with real patients and learn about 'being' a doctor and 'practising' medicine thereby according 'attitudinal objectives' equal importance to 'knowledge objectives' and 'skills objectives'. More recently the Modernizing Medical Careers initiative has reinforced this, and required medical doctors to improve their inter-professional cooperation skills (www.mmc.nhs.uk). Additionally, there have even been calls from within the profession to embrace the complexities of healing, to reconnect to the original role of the health professional as 'healer' and 'to engage [the patient] in becoming an active partner in the therapeutic relationship' (Sturmberg, 2005). Indeed, May and Sirur (1998), in their study of doctors who used homeopathy in their general practice propose that in order to fulfil the recent professional rhetoric about the importance of the interpersonal relationship between doctor and patient, medical students should be taught the (detailed and socially-sensitive) method of homeopathic consultation as an ideal model of general medical practice.

New educational interventions being promoted for medical students include a drive for 'patient-centred medicine' and community based medical education (Thistlewaite & Jordan, 1999; Worley, 2002). The community environment, it is argued, gives students a better opportunity to develop 'patient-centred' case history-

taking skills. Thistlewaite and Jordan's research with medical students found that they experienced their embodied presence in the (hospital) clinical training environment as precarious: 'students saw their training as vulnerable to, and unprotected against, both chance circumstance and the (lack of) goodwill of others, whether these be patients or staff' (1999: 681). On the other hand, community training, the students felt, offered them a chance to experience less contrived interviewing situations: 'the opportunity to consult with patients with new problems meant that patients were likely to "present" in ways similar to a "normal" GP situation' (1999: 681).

Other attempts to promote a more patient-centred approach in medical education include teaching literature and other humanities (Shapiro et al., 2004). However, some teachers have experienced resistance from students to confronting issues of inequality and oppression in ways that might directly relate to their own power relationships with patients (Wear & Aultman, 2005). One crucial problem with teaching these skills to medical students is how different forms of knowledge are valued. The 'soft' skills of interviewing are often taken for granted, or seen as unspecialised and therefore devalued. Fadlon et al. suggest that 'employing a structured model for teaching doctor-patient communication skills awards psycho-social issues the status of formal knowledge' (2004: 35). However, despite the importance that students claim to assign to the patient-centred approach during their training (Thistlewaite & Jordan, 1999), students tend to show a decline in their abilities to take a social case history over time, perhaps due to the pressures of time in the clinical encounter and to the culture of medicine that they are exposed to (Pfeiffer et al., 1998).

Kleinman's (1980; 1988) work on 'illness narratives' has been extremely influential in identifying psycho-social influences on ill-health. 'Narrative medicine' is becoming an increasingly popular topic for medics (e.g. Charon & Montello, 2002; Greenhalgh & Hurwitz, 1998; Hurwitz et al., 2004; Lapsley & Groves, 2004) as well as social scientists (e.g. Bury, 1982; Bury, 2001; Williams, 1984). However, it is important to recognise the influence of the nursing profession in changing the terms of the debate about what constitutes valid knowledge, as it has been responsible for pioneering 'care-driven' practice within the orthodox medical social system and introducing the concepts of emotional intelligence and reflection into everyday practice (Freshwater & Stickley, 2004).

Nursing research has been important in identifying the value and distinct skills required to 'care' for patients. A traditionally 'feminine' quality confined to the private sphere, caring has become crucial to the unique and distinct knowledge and practice that nursing claims jurisdiction over, especially as compared to medicine (MacFarlane, 1976). Indeed, the transfer of nursing training to higher education, and the debates on what training is required, has also stimulated debate on the constituents of nursing practice, with a great deal of emphasis being put on the notion of an 'emotionally-intelligent practitioner, one for whom theory, practice and research are inextricably bound up with tacit and experiential knowledge' (Freshwater & Stickley, 2004: 91). Benner (2001) has stressed the role of developing 'intuition' in nursing practice, which goes beyond the acquisition of academic knowledge or physical skills, although it has been noted that the paucity of the English language for describing intuition means that it is often difficult for people to articulate their intuitive reasoning behind actions in practice (Brawn, 2000: 153).

However, this and other professionalizing strategies adopted by the nursing profession are far from being unproblematic. For instance, from the point of view of nursing education, there still exists pressure to prioritize academic and scientific skills. Gerrish et al. (2003) comment on the lack of emphasis given to the caring mandate in master's level education. The roles envisaged for these master's level nurses was in service development, education and, tellingly, 'knowledge and skills to assume a more medically orientated role in the workplace' (Gerrish et al., 2003: 110). In a similar vein, Foley and Faircloth (2003) have observed that 'narratives of legitimation' are adopted by midwives to elaborate their complex relationship with the medical model. Firstly, they use narratives as a device to delineate the boundaries of their practice, and contrast it with medicine; secondly, they draw on it to communicate necessary aspects of their daily work, and thirdly, they construct a story of medical collaboration that equates their work with that of physicians.

As well as emotional and caring skills, reflective practice is gaining increasing currency in debates about professional knowledge and skills. For instance, portfolios are becoming increasingly popular as a 'reflective' learning tool in the education of medical students and other healthcare professionals. They challenge the more traditional science emphasis of medical curricula, as they focus on communication, personal reflection and other so-called 'soft' skills. Driessen et al (2005), writing in a medical education journal, propose that key to the success of portfolio assessment is to have a good introduction to the portfolio and its intended use, student ownership, a clear structure, and appropriate use of the portfolio in discussions with coaches or trainers. This has the effect of formalizing the reflective self-development of the student. However, as Eraut notes, 'the emotional dimension and broader aspects of

learning are under-researched and under-theorized, and their interconnections are rarely mentioned' (Eraut, 2004: 3).

Many of the recommendations from *Tomorrow's Doctors* are slowly being incorporated into medical curricula with many of the 'new' medical schools taking the lead in this area (Houghton & Gray, 1997: 12). However, 'new' institutions seeking to legitimize their focus on problem-based learning, rather than on basic science, have had to contend with the higher prestige of medical colleges that emphasize the 'hard sciences' (Brosnan, 2005). Challenging the cultural dominance of stereotypically 'masculine' forms of knowledge – 'hard science' over 'soft skills' – has not been as readily achieved as many reformers might have hoped. The cultural devaluing of non-scientific knowledge within health care presents huge problems for other healthcare professions. While professions such as nursing and midwifery have employed rhetorical and practical strategies to resist this and affirm their own distinct forms of knowledge, in a large part through educational strategies, much less is known about CAM practitioners.

Most of the information about CAM training has been part of studies about professionalization drives. Generally, CAM practitioners seeking to legitimize their form of health care have two choices: either the designation of a *distinct* yet *collaborative* (or at least non-competitive) relation to medicine, such as prevails in nursing, or the presentation of a viable *alternative* to orthodox medicine. In osteopathy there has been a lack of consensus about which approach to take. Baer (1984) observes that while some osteopaths have sought to establish their identity as 'musculoskeletal specialists', others have stressed the need to function as 'general practitioners', a position born of the holistic health movement. The former, Baer notes is 'a niche far less threatening to the medical establishment than if they were to

function as heterodox general practitioners' (1984: 720). Many of these debates and changes have taken place within the educational institutions which inevitably shape the future direction of the profession. Since Baer's paper, the Osteopaths Act (1993) has granted the profession statutory regulation emphasizing the 'musculoskeletal specialist' role, but the dispute continues within the profession as many of today's educators were taught in the classical, 'holistic' osteopathic tradition.

Equally the debate between collaborative and alternative approaches has been alive in British homeopathy. Homeopathy has been part of the National Health Service since its inception in 1948. There are five homeopathic hospitals and over one thousand GPs practise homeopathy alongside conventional treatments (Vickers & Zollman, 1999). However, throughout this time there has been a 'lay' (non-medically qualified or NMQ) homeopathic community that since the death of the early 'charismatic' leaders has organised its own training schools and professional organisations (Cant & Sharma, 1996). The knowledge base and training is vital to any profession's claims to legitimacy, and Cant and Sharma have observed among both groups of homeopaths 'a concern to de-emphasize the more controversial teachings', the dropping of the 'esoteric and druidic elements' of the practice, and the incorporation of certain 'mainstream medical teachings', especially anatomy and physiology (1996: 585). Nonetheless, this is not a universally accepted trend, and some homeopathic colleges have sought to build on aspects of the more esoteric heritage of the practice. The length and the nature of the training offered to student homeopaths is at the centre of the debates that the Council for Organisations Registering Homeopaths is engaged in, with the aim of developing a 'single register' for homeopaths (CORH, 2002).

Fragmentation and diversity within the field is widely recognised to be a significant challenge to regulation (Prince of Wales' Initiative on Integrated Medicine, 1997). Welsh et al. (2004) have examined the situation of CAM in Canada and they argue that professionalization has been 'fraught with tensions'. Various strategies have included improving educational standards, developing high standards of practice, engaging in peer-reviewed research and increasing group cohesion. This latter strategy has arisen partly in response to battles within practitioner groups about the incorporation of orthodox medical science into the knowledge base (Welsh et al., 2004). In general, there is a lack of consensus in CAM, in general and within specific practices, about what should be promoted as the profession's unique knowledge claims. In a political climate that is moving towards increased regulation of CAM professions, and bearing in mind the vociferous debates about legitimate professional knowledge and skills in the various orthodox medical professions, research on the training of CAM practitioners is timely. As CAM therapies are often based on a fundamentally different model of health care, it raises the question about how knowledge and skills are valued, 'taught' and 'learnt' in the training environment. Documenting the formal and informal training process, and the lived experiences of students of CAM, including how they develop professional identity and a way of being-in-the-world that is appropriate to their therapeutic practice, can potentially contribute to these debates.

Developing professional identity

Classic studies of medical training have often focused on how students come to identify with and become committed to professional norms, drawing on theories of

‘professional socialization’ (e.g. Becker et al., 1961; Merton et al., 1957). However, more recently, critical sociologists have come to question the apparent simplicity of the socialization concept, highlighting the importance of individual agency in resistance to cultural norms, and the diversity of meanings and types of ‘professional identity’ that a student may aim for. In addition, the importance of embodiment in the experience of student practitioners has been neglected.

Clearly, to a large extent, students do gradually develop attitudes, values and dispositions that resemble those of their predecessors, which supports the socialization thesis. Many of these can be seen to be the result of the structure of the learning environment. For instance, Atkinson notes that for medical students ‘the process of diagnosis is highly valued and success at it is a source of some pride’ (1981: 31). This ‘pride’ can be seen to be a response to the uniqueness of the diagnostic capabilities in the doctor’s role, and as part of what defines a doctor. However, the centrality of diagnosis is also built into the structure of knowledge sharing and assessment in the profession. Aspach (1990) shows that case presentations are a key instrument in medical students’ learning experience, and include both listening to others and giving their own presentations to superiors. The case presentation, therefore, becomes a form of self-presentation. What is learnt here is tacit, part of the taken-for-granted aspects of practice and the use of language conventions and the use of ‘appropriate’ language with colleagues or patients reinforces the different roles of the actors in the setting. Anspach argues that the ways that language is used in the case presentations reinforces the dominance of the medical model thereby devaluing patients’ accounts: ‘practices... both reflect and create a world view in which biological processes exist apart from persons, observations can be separated from those who make them, and the knowledge

obtained from measurement instruments has a validity independent of the persons who use and interpret this diagnostic technology' (Anspach, 1990: 335).

Musselman et al. (2005) even observe that medical students come to 'rationalize' intimidation from tutors if '(1) an acceptable *purpose* can be attributed to the perpetrator; (2) a positive pedagogical or clinical *effect* of the behaviour, and (3) a perceived *necessity* for the behaviour to achieve the purpose' can be established (2005: 930). In these accounts, repeated exposure to and practice of these values and skills is seen to result in their absorption. Thistlewaite and Jordan note that medical students learning about case-taking actively identify positive and negative role models according to the respect that they show for the patient and his or her concerns. However, the students are aware that continual exposure to what they perceived initially as 'unacceptable' behaviour becomes acceptable over time, because they realise that indifference to patients was an inevitable consequence of the habitual nature of the work (1999: 681-2).

The concept of socialization is widely used and criticized in the social sciences, often in the context of children acquiring social skills that fit in with the adult society that they live in. There are two main problems with the extension of this concept to professional contexts: firstly, that it does not account for the agency of the student and secondly, that the body is poorly conceptualized. The professional socialization model is limited by its portrayal of the students as a passive vessel for the information and skills that are accepted by the profession. Concepts such as the 'assimilation of medical values' (Becker et al., 1961), 'invisible pedagogy' (Bernstein, 1975), and 'legitimate peripheral participation' (Lave & Wenger, 1991) can imply a kind of unquestioning acceptance and absorption of the values of the professional group by students. Perhaps only in the most traditional of lectures could

the role of the tutor be simply that of 'imparters of knowledge', and even then the lecturer's self-presentation would have an impact on the students' attitude towards and valuing of the knowledge that was presented. Students undoubtedly learn a huge amount about the social meanings of doctoring through the nature and content of the interactions with their tutors, but they do not accept all values uncritically.

Clouder (2003) advocates adopting a social constructionist perspective on professional socialization, seeing 'socialization as interaction' and making explicit the scope that individuals have to exercise personal agency within the training process. Her research with student occupational therapists reveals the ways that students can use their agency in the system by 'learning to play the game' or 'presentation of self'. Her analysis draws on Goffman's idea of 'impression regulation' and Bourdieu's model of 'the game'. However, she still concludes that ultimately 'the game' is prescribed by the profession and 'those who wish to join the profession need to adapt accordingly to gain membership' (Clouder, 2003: 220). Her analysis is limited because 'the profession' in her analysis seems to be a fixed and unified group. However, a profession is an evolving social entity which students can influence, not only resist. Other research identifies similar strategies that students use to negotiate the training process, such as performing in a way that maximizes the evaluations given by superiors (Knafl & Burkett, 1975) and 'psyching out' instructors in order to establish what they want to see in order to be able to produce it for them (Light, 1979). It is possible also that 'professional conversations' are vital to the transformation of professions as well as their reproduction. Phillips et al. (2002) use the framework of 'positioning theory' to analyse the process of 'reflection' and the development of personal identity within the social institution of midwifery. They argue that it is vital to emphasize the 'person' as against the 'role' in this analysis, so

being able to see the potential for resistance and transformation. Lave and Wenger's (1991) work rethinks the concept of apprenticeship: 'Legitimate peripheral participation is proposed as a descriptor of engagement in social practice that entails learning as an integral constituent' (1991: 35). Students learn about what it 'means' in practice to be a professional through interactions with more experienced members of the profession.

However, in all of these accounts, these professional values seem to be absorbed in a rather disembodied fashion. For instance, Light notes, in relation to clinical competencies, that trainee medics 'get taken in by their own act until the self-conscious process of role simulation becomes the real thing' (1979: 313). It is unclear here exactly how the repeated exposure to professional ways of being actually changes the student's embodied practices and belief systems. In many ways it is clear that the body of the doctor or other healthcare practitioner is vitally important to the clinical encounter; for instance, the use of uniforms and practical skills-based training clearly implicate the body of the practitioner. The following statement from a doctor vividly illustrates the importance of embodiment:

We were trained for seven straight years, twelve or more hours daily to think disease, diagnosis and treatment as the sole means of managing illness. The model is *embedded in our very bones* and it becomes almost impossible to think clinically in any other way (Allen Barbour, MD, cited in Taffler, 1998: 24, *my emphasis*).

Yet in both professional literature and sociological research the body has often remained an 'absent presence' (Shilling, 1993: 9). For instance, there may be hints of the body in the sociological literature, such as the limitations of 'book knowledge' and the importance of 'the experience perspective' (Becker et al., 1961), but this has

not been conceptualised from an embodied perspective. This ‘absent presence’ may in part be due to assumptions made by researchers about the nature of medical knowledge and the process of acquiring new knowledge. For instance, Fox’s (1957) classic work on ‘training for uncertainty’ identifies three aspects of uncertainty that the student physician must confront and come to terms with: their own incomplete or imperfect mastery of available knowledge, limitations in current medical knowledge, and the difficulty in distinguishing between the two. Although her work was welcomed by doctors as portraying a more realistic view of the difficulties of daily medical practice, the critical value of her work is limited for sociology by her failure to problematize the form and structure of medical knowledge. Her analytical framework assumes a knowledge hierarchy that places ‘scientific’ medical knowledge at the top. Students and physicians can never accumulate all this ‘stock’ of knowledge, and this may indeed explain the tendency to specialization. Her model does not allow conceptual space for embodied knowledge. Other commentators have questioned Fox’s focus on uncertainty and observed that ‘the uncertainties of a treatment threaten the *raison d’etre* of a profession and must be controlled’ (Light, 1979: 312) and so ‘in... [training] contexts medical students are *not* occupied by radical doubts and plagued by uncertainty. Rather they set about the pragmatic accumulation and construction of a stock of knowledge’ (Atkinson, 1984: 952). However, these critiques are still unable to adequately account for the ‘embodied’ knowledge of healthcare practitioners that goes beyond the books.

What is crucial to recognize is that the embodiment of the doctor-subject (or any other health practitioner) can not help but impact on the social encounter that is the treatment. At the most basic level, every actor in a social environment brings with them a culturally mediated identity. Medical students begin their education already

‘educated’, ‘cultured’ and usually ‘middle-class’ (if no longer also ‘white’ and ‘male’). Medical training can be argued to reinforce and validate a certain form of cultural capital. Cultural markers are imposed (or embraced) such as the uniforms (‘the white coat’) or technical instruments (‘the stethoscope’) which serve to reinforce the social positioning of actors in the setting. Conventions such as white coats or scrubs, and the use of bodily etiquette, such as having warm hands and not sitting on the patient’s bed, have helped ‘to preclude confusion between the contact of medicine and the contact of intimacy’ (Emerson, cited in Atkinson, 1981: 43). Nevertheless, in sociology, despite a recent burgeoning interest in ‘embodied’ sociological work, little has been done to establish what implications this analytical approach has for our understanding of medical training and, even less, for our understanding about ‘alternative’ medical practice and embodied learning. This seems all the more vital to explore because of the clearly embodied nature of the ‘healing encounter’ be it between patient and surgeon, talk therapist, or osteopath.

There are, however, some notable exceptions and evidence of a new direction in research, led by the nursing profession. Some studies have been concerned with making explicit the embodied aspects of healthcare practice and education. Shakespeare argues that in nursing the predominant trend has been to ‘write out’ the body of the practitioner in instructional texts, through wording such as *‘the stethoscope must not be pressed firmly... excessive stethoscope pressure... non-support of the patient’s arm’* (Shakespeare, 2003: 52). The body of the practitioner is made invisible through elliptical language that makes explicit only the body of the patient. This invisibility may go some way to explaining why sociologists have rarely focused on the embodied aspects of healthcare practice either. Shakespeare calls for

researchers ‘to examine bodywork as a topic for investigation rather than a given’ (2003: 52).

‘But why is it worthwhile? Because nurses’ bodies are a medium for both nursing practice and knowledge (for example, understandings of others’ physical or psychological conditions may be mediated through touch), relationships with other professionals and patients may be facilitated through physical posture, clinical encounters are accomplished through embodied activity, health and safety regulations are acted out through embodied activity and such diverse things as approval, disapproval, skills, expertise and humour are all registered and understood through bodies’ (Shakespeare, 2003: 54).

Lawler’s (e.g. 1991; 1997) path-breaking work on the ‘somological approach to nursing’ has brought the body of the nurse into the realm of academic discourse, although it has long been recognised that expertise in health care is ‘something more’ than effective learning of relevant facts. Benner’s (2001) classic nursing study *From Novice to Expert* highlights this: ‘Theory offers what can be made explicit and formalized, but clinical practice is always more complex and presents many more realities than can be captured by theory alone’ (2001: 36). However, this kind of expert or ‘intuitive’ practice is very difficult to communicate verbally (Atkinson & Claxton, 2000).

Other studies with an explicit focus on practitioner embodiment include Spinelli and Marshall’s (2001) edited collection of writings by psychotherapists who were asked to explore what and how it is for them to ‘embody their chosen therapy’. Issues such as interaction with clients, self-presentation and personal experiences and situations are all explored by the contributors sensitively and reflectively. Cassell’s ethnographic study *The Woman in the Surgeon’s Body* gives a detailed account of the

value of reading surgery as an embodied occupation. She suggests that it is possible to see that ‘the body of a woman who aspires to be subject (she who acts) rather than object (she who is acted upon) seems bizarrely out of place to their martial masculine practitioners’ (Cassell, 1998: 12). In one chapter, she describes a woman who ‘literally survived’ her residency: ‘Dr Stephen was obviously the wrong body in the wrong place, in a geographical area where women's bodies had specific movements, meanings, and symbolic values that were alien to her. Not only her gender but everything about her habitus was wrong’ (Cassell, 1998: 206). However, Cassell does not ask how far it is possible to challenge these meanings in medicine. This raises the question as to whether ‘alternative’ forms of medicine would value other types of bodies. The process of ‘becoming’ a member of a new profession brings with it much more than a set of new ‘objective’ facts; it entails a reconstitution to some degree of praxis, of being-in-the-world and of perception.

This discussion has identified a significant gap in the sociological literature relating to the *practice* of CAM therapies, and specifically to the ways in which students experience their education in preparation for professional practice. Research conducted with an explicit concern for embodiment has far greater potential to give insights into the development of ‘expertise’ and ‘intuition’ in practice, which is often difficult to explain verbally. Training provides a particularly good way of gaining access to these embodied skills and knowledge that practitioners have about the body, because the focus of the social setting is also on the bodies of the students (rather than just on the bodies of patients). In addition, training provides a path to understanding the ways that professional power and identity can be embodied. Two key areas of research interest emerge related to professional knowledge and identity: (a) In what

ways is knowledge about health and healing re/produced by alternative medical communities in the learning environment? What is the form and structure of that knowledge (in theory and practice)? And (b) In what ways do students negotiate the learning process and to what extent does this shape or change their embodied identities?

Knowledge, identity and embodiment: towards a theoretical framework

Given the relevance of the body and embodiment to research on the training of CAM practitioners, and the scarcity of research on the topic, it seems appropriate at this point to cast a wider net over the sociological literature, to explore what theoretical frameworks might be useful for the development and analysis of this research, and to further establish what research on the training of CAM practitioners may be able to offer to embodied sociology, and vice versa, how embodied sociology can illuminate the students' experiences. I will explore the potential purchase of Pierre Bourdieu's ideas, including his concepts of 'habitus', 'social field', 'symbolic violence' and 'doxa', on aspects on this research. However, drawing on contemporary critiques of Bourdieu, I will argue that we need to rethink his understanding of reflexivity, and give a deeper consideration to questions of emotions as a form of capital and the possibilities for resistance to symbolic violence.

The work of Bourdieu may offer a useful framework for analysing changing professional identity that brings the body into explicit focus. For Bourdieu, education is the key mechanism through which the values and relations that make up a particular social space are passed on from one generation to the next (Webb et al., 2002: 118). Bourdieu's work contrasts with the professional socialization models, critiqued above,

which pay little attention to embodiment. In as much as it would be possible to imagine an embodied perspective to the professional socialization model, it would be likely to be an early Foucauldian ‘docile’ body: a blank surface on which power relations are inscribed. In addition, Bourdieu’s work contrasts with approaches that, at the other end of the spectrum, overemphasize the capability for reflexive transformation, such as the work of Giddens, whose engagement with the body and embodiment is very limited and limiting (Turner, 1992; Williams, 2001). Bourdieu emphasizes the relative intractability of bodily customs and habits; the *habitus* tends towards reproduction rather than transformation, suggesting ‘a layer of embodied experience that is not immediately amenable to self-fashioning’ (McNay, 1999: 102). The only way to escape from the freedom/ determinism debate, Crossley argues, is ‘to learn to think of agency in terms of purposive and meaningful conduct, shaped by habit’ (2001: 136). McNay defends Bourdieu against criticisms of determinism by pointing out that Bourdieu considered habitus to be a generative structure, where social life is filled with ‘social actors’ rather than ‘subjects’ (McNay, 1999: 100, 101).

For Bourdieu, the body is ‘a bearer of symbolic value’ (Shilling, 1993: 127). Essentially an unfinished entity, its development and commodification in interaction with social forces is fundamental to the reproduction of social inequalities. The habitus is ‘a system of lasting, transposable dispositions which, integrating past experiences, functions at every moment as a matrix of perceptions, appreciations and actions’ (Bourdieu, 1977: 83), and knowledge is always constructed through the habitus, rather than being passively recorded (Webb et al., 2002: 38). Bourdieu’s concept of ‘le sens pratique’ (the feel for the game) offers a route to conceptualizing the forms of knowledge learnt by the body that cannot be explicitly articulated (McNay, 1999: 101). This may be useful for explaining ‘intuitive’ skills that

practitioners in all professions develop (see for example Atkinson & Claxton, 2000) or the development of professional expertise when practitioners can ‘zero[...] in on the accurate region of the problem without wasteful consideration of unfruitful, alternative diagnoses and solutions’ (Benner, 2001: 32). In the context of the education of CAM practitioners, it is possible to ask whether, and to what extent, students develop ‘new’ or ‘alternative’ dispositions and bodily habits and form a ‘homeopathic habitus’ or an ‘osteopathic habitus’.

Another key aspect of Bourdieu’s approach (as Karakayali, 2004, notes, Bourdieu prefers not to think of his works as ‘theories’ but as ‘exercise books’) is the role that the ‘field’ plays in the social world. The field is a ‘set of *dynamic organizing principles*, ultimately maintained by social groups, which identify and structure particular categories of social practices’ (Shilling, 1993: 138, *emphasis in original*). The field, therefore, assigns symbolic value to certain forms of habitus. It may be that in non-orthodox medical communities, different bodily habits and skills would be valued compared to dominant medical or the general culture. If so, this would have significant impact on the experience of the students, who may, for instance, find that they have unexpected positive and negative responses to certain aspects of their embodied self. Additionally, Bourdieu understands habits to be ‘transposable’ between fields of practice, so it is possible to see that professional training may have far-reaching implications in a person’s social habits beyond the geographical and professional confines of the learning experience, and vice versa. Communities of learning are not experienced in isolation from other social practices so changing practices can ‘spill over’ to many other areas of the person’s life (such as financial and emotional) and potentially transform them.

Another two of Bourdieu's concepts, 'doxa' and 'symbolic violence', may be useful to further explicate the validation of, and challenge to, different ways of knowing. Doxa is that which is undisputed by social actors: 'doxic beliefs are unquestioned beliefs, embodied in action and feeling but seldom formulated in words' (Crossley, 2001: 99). As it is difficult to access these beliefs consciously, it is also difficult to reflect upon them or to change them. 'Symbolic violence' is 'the violence which is exercised upon a social agent with his or her complicity' (Bourdieu, cited in Webb et al., 2002: 25). Where doxa operates in a field, symbolic violence is misrecognised as the natural order of things, which clearly has implications for different ways of knowing and being. In the context of CAM, the dominance of mainstream 'science' means that CAM practitioners' acceptance of a 'non-science' label can mark them as inferior to orthodox medics. Dixon-Woods et al. (2006), drawing on work on 'informed consent' in medicine and its limitations as a safeguard to autonomy, demonstrates using Bourdieusian analysis that, at a micro-level as well, power is bound up in cultural concepts and practices of 'experts':

Bourdieu's concepts of habitus, capital and symbolic power/violence offer a potentially more elaborated account, by showing how the practical logic that women apply in the field of surgery confers a 'sense of place' relative to professionals. Women experience deficits in capital, intensified by their physical vulnerability in critical situations, that severely constrain their ability to exercise choice (Dixon-Woods et al., 2006: 2742).

For student practitioners of CAM their interactions in the learning environment, both with tutors and patients, will be mediated through power relations. It will be important to understand the extent to which they reproduce or resist conventional power relations relating to, for example, valid knowledge about health and healing.

However, in order to make Bourdieu's approach a more useful tool for this research, it is necessary to critically develop his concept of reflexivity and to give more consideration to emotions and the potential for resistance to power. One critique of Bourdieu's approach is that he does not adequately explain how an ordinary social actor can achieve reflexivity. Reflexivity seems to be the domain only of the cultural commentator or sociologist. McNay argues that Bourdieu does not deny the possibility for reflexive self-awareness, but that the notion of reflexivity 'must be qualified with a differentiated analysis of attendant social relations and lead to a more qualified account of reflexivity as a capacity of the agent that is unevenly realised' (McNay, 1999: 111). Crossley offers another solution to this problem of reflexively monitored change. Basing his ideas on an 'intersubjective' theory of reflexivity – 'our capacity to turn back upon and inspect ourselves derives from an incorporation of the perspective of others into our habitus' (Crossley, 2001: 6) – he draws on the phenomenological notion of the intentionality of consciousness to place reflexivity firmly within the habitus. He argues that Bourdieu's work is limited by his failure to see reflection and choice as an integral part of habitus, rather than as different modalities of action. This, he argues, is an essential step to take in order to support Bourdieu's view that it is wrong to see that 'the reflexivity achieved by way of sociology is a mysterious act of a transcendental subject' (Crossley, 2001: 138). Reflective practice, a concept that is now taken for granted in professional education (Eraut, 2004), needs to be rooted in the body if the concept is to be useful to this thesis.

A significant part of the role of healthcare professionals (and other workers, cf. Hochschild, 1983) relates to the management of emotions, but Bourdieu talks very little of emotions in his work. His concept of capital accumulation does not take into

account emotional capital which has a complex and indirect relationship with cultural capital (Reay, 2004; Williams, 1998). Doctors' medical skills are perceived to be of much higher economic value than the skills of nurses, counsellors, traditional healers and unpaid carers, that are nonetheless vital to the functioning of healthcare systems. Bourdieu, therefore, replicates the lack of visibility and value assigned to emotional skills and resources. Skeggs (2004b) argues that values such as altruism, integrity, loyalty and investment in others are missing from Bourdieu's analysis. These non-accumulative, non-convertible values are, however, central to social reproduction especially gendered reproduction, she argues. Probyn (2004) argues correctly that emotion is a key part of the body's knowledge and that Bourdieu's tendency to avoid the significance of the feeling body has implications for gender issues. The inclusion of the concept of emotional capital may also be an essential analytical tool to explore questions about the knowledge required for 'holistic' health care practice.

Finally, it is important to consider the potential for resistance to symbolic violence. Skeggs argues that Bourdieu's 'gendered and sexed habitus can only ever be reproductive because it is locked within that which produces it. Bourdieu's analysis is performative of the categories it seeks to critique' (2004b: 27). However, habitus is not a fixed concept, and its social meaning is changed according to the social field in which the body-self is (spatially) located. There may be, in certain fields, successful forms of resistance to symbolic violence. Drawing on her work with working class women and 'queer' ambiguity, Skeggs suggests that 'authorization can be produced at a local level by taking a different perspective and re-valuing the positions we are expected to inhabit without value' (2004b: 25). This may be relevant for understanding how both CAM values and learning about them are validated. Nonetheless, it is important to recognize Bourdieu's observation that pedagogic

action, or teaching of the ways of the world, is a principle form of symbolic violence, which promotes certain doxa and consecrates certain positions and lifestyles (Webb et al., 2002). It may be that students still remain subject to certain kinds of symbolic violence even if they are resisting orthodox medical beliefs and practices.

Conclusion

Learning is... incorporation, and absorption of new competencies and understanding into the corporeal schema which, in turn, transform one's way of perceiving and acting in the world (Crossley, 2001: 128).

This chapter has explored debates and questions in the existing literature around the contemporary rise of non-orthodox, or complementary and alternative, medicine, and the nature of power and knowledge in health care fields. In particular, it has considered the value of placing embodiment at the centre of a sociological analysis of the practice of CAM. The value of research on the training of practitioners is the explicit focus on the body of the practitioner that the setting permits, and the potential for gaining understanding of the assumptions that underpin day-to-day practice. The chapter has shown that there are a number of sociological debates relevant to the training of healthcare practitioners but that research has rarely given serious consideration to questions of embodiment. Through research on the training of osteopaths and homeopaths, this thesis intends to explore the nature of the 'competencies and understandings' that student-practitioners develop, how they influence perception of the body in society, the actions of practitioners, and why some are resisted while others are absorbed. Finally, the chapter developed a theoretical

framework for the development and analysis of the research drawing on Bourdieu and further developments of his work.

With a direct focus on embodied experience and the value assigned to different forms of knowledge and professional ways of being, this research intends to contribute to the emerging discipline of embodied sociology, as well as to the sociology of health and illness, of professions and of education. This will be of interest not only to sociologists, as a substantive empirical area or as a potential tool to elaborate the role of the body in learning and social practice, but to policy makers and professional groups with an interest in the development, legitimation and regulation of CAM.

Researching practitioner training: a methodological account

Introduction

From the viewpoint of *after* being in the field, it is easy to forget where I started and the ups and downs along the way, but my body, in the widest sense of that word, has been a witness to the whole process and bears the gifts and scars of the experience. My habitus, to borrow the term, has changed in many ways from the beginning but, fundamentally, I am probably much the same. I am still (in no particular order) a woman, a feminist, English, white, bisexual, middle-class, a sociologist, and as one of my very good friends put it, ‘in to all that hippy shit’. However, spending hours, weeks and months alongside my participants, working with them, experiencing and learning with them, talking and interacting with them in various ways, in and out of the institutional setting of the colleges, has produced changes. Many of the ways that I see and interpret the world and the people around me have changed, and the thesis I write today is *from* the embodied person that I am on this day. Writing this thesis has been at once the most challenging and the most rewarding part of the process, as it has forced me to crystallize my experience into words – to make it clear and tangible, something that in the context of the settings was often a challenge. And for my participants, with all their complexity, I sought to honour their experience, while retaining my critical sociological edge.

In this chapter, by concentrating on three cross-cutting and non-linear aspects of the research process – motivation, immersion and expression – I draw out the conceptual links between theory, practice and ethics in ethnographic research, as well as shedding light on the direction that the study took and the claims to validity of the findings.

Planning and motivation

This study was born of a passion for sociological research, and a frustration with the lack of consideration given to alternative forms of healing in a sub-discipline (sociology of health and illness) that has torn itself from, in name at least, its origins in the service of medicine (medical sociology) (see Williams et al., 1998 for a good summary of the history of the sociology of health and illness). Undergraduate and postgraduate courses on the subject usually at best manage a week on ‘Complementary and Alternative Medicines’.

One of the most common questions I am asked by non-academics when I say I’m doing a PhD is ‘How on earth do you find the motivation?’ and the answer, I believe, can be best explained by drawing out the embodied aspects of being a researcher. Motivation, clearly, is required for all parts of the research process, from submitting funding applications, to picking myself up after knock-backs about access to the field, to resisting the allure of sunbathing in the garden when chapters have to be written. My desire for doing research can in some ways be attributed to the fact that I have grown up and developed as a student and sociologist in a culture and institutional environment that values academic achievement. My successes in this area (I’d have never made a good concert pianist, as my childhood piano teacher –

and now, in a twist of fate, my Reiki Master – would have told you!) have brought great personal and professional satisfaction and rewards. The training I have undertaken, and the culture I have participated in, for seven years as a student and teacher have validated my goals as worthwhile. Indeed, the validity of academic achievement as a goal, as a middle-class schoolgirl in the UK, was drummed into me from a very young age.

However, my integration into academia has been a hindrance as well as a help for this research. As one tutor at the College of Homeopathy told me, ‘Academics make the worst patients because they are so *in their heads*.’ This way-of-being (‘in their heads’) may offer one insight into why the body and embodiment has emerged as a key sociological problematic in sociology only in recent years. The idea of *thinking from* our bodies, or *through* our bodies is a difficult thing to achieve when what our bodies seem to do best is to *do* or *feel*. We perhaps find it easier to use our heads to explore some emotive situations that cross the apparent boundaries of body and society (‘I think I am happy’ or ‘I think I am in love’) but some aspects of the physical body demand a gritty temporality that makes ‘I think my leg hurts’ a nonsense. Perhaps this is why diagrams of nerve pathways or debates on the social causations of disease come more easily to the scientist or academic. My motivation then is to facilitate the process of sociology coming to find a way to meaningfully express and, of course, critique the role of embodiment in the social organisation of health care. My challenge is to explain in an academic context, and through academic writing, professional practices that draw variously on wordless bodily sensations, emotional empathy, intuition, spiritual experience and ‘subtle energetic fields’.

Developing the focus of the research started with an interest in practitioners’ experiences. As Chapter One demonstrated, the majority of the academic literature

that there was on CAM focused on efficacy debates, historical and social patterns or patient usage and perspectives. The finding from my Masters research for which I interviewed experienced teacher-practitioners from a variety of therapeutic disciplines showed that, at least to some extent, these practitioners become an ‘embodiment of their therapy’. This insight begged the question of how and why this happened, and the dearth of research on training in any form of CAM made this an exciting potential subject. In addition, the growth of popularity of CAM, the increasing numbers of people training (often as a complete career change) to be practitioners, and the increasing political demands for regulation and accreditation of CAM made questions of ‘what’ was being learnt and how competence could be validated, extremely topical ones. As Fox argues, from a perspective of the ethics of postmodern research where knowledge is ‘local and contingent’, ‘research questions should be developed in such a way that the theoretical consequences will be of direct practical relevance’ (1999: 190).

Motivation, and the desire for knowledge, is then at once individual (produced day on day through my habitus and my personal and political commitments) and social (through the requirements of the PhD process, the ‘gaps’ in sociological knowledge, the social values assigned to academic status, and interaction with informants). My desire may be reflective of those social values but it also contributes and (albeit minutely) modifies them as it is enacted. My body, for instance in terms of the capital it is accruing, plays an important role in the motivation, but being a researcher requires training and the embodied student researcher must learn new dispositions and practices. In a way, the learning of any new discipline has the potential to be an interesting subject of study for embodied sociology. The unique value of this study with CAM practitioners is the extent to which embodiment is

explicitly recognized in the training process, and (as later chapters explore) the distinctiveness of the ways in which the body is implicated in the training process for the student homeopaths and osteopaths.

The choice of the two case studies – the anonymized Colleges of Homeopathy and Osteopathy – was motivated by three main concerns. Firstly, I wanted to choose CAM therapies that had a long training course, so that I could spend a whole academic year in the settings, preferably with the opportunity to spend time with different year groups. Secondly, opportunities for access were vital. I needed to consider a feasible geographical location for conducting two case studies, and it made sense to build on personal and professional contacts to assist in gaining access. Thirdly, I was interested in the comparative potential of the case studies, both with each other, and with the existing literature on orthodox medicine and allied professions. Osteopathy was chosen for its fascinating position as a newly state-regulated health care profession. It has become increasingly integrated with orthodox medicine², such as through the development of some referral procedures, and overlaps with the core medical education curriculum, in particular anatomy and physiology (see Chapter Three). Homeopathy occupies a much more ambivalent position in the social organisation of health care. Historically, as Chapter One demonstrated, it has had a long, complex and often antagonistic relationship with orthodox medicine. However, even since the inception of the National Health Service homeopathy has retained a foothold, albeit a small one, in the orthodox profession, in the form of NHS homeopathic hospitals (e.g. www.rlhh.org.uk) and the Faculty of Homeopathy (www.trusthomeopathy.org). Alongside this the independent, ‘lay’ profession, that

² Although as noted in the previous chapter, the changes required to move towards integration and to achieve government regulation have not been universally welcomed within the profession. Many argue that the ‘core’ principles of osteopathy have been lost in pursuit of ‘scientific medical’ approval.

comprises non-medically qualified homeopaths, have managed to sustain their self-identity as ‘professional homeopaths’ (Cant & Sharma, 1996), despite being readily rubbished and ridiculed by orthodox medics. In turn, the professional homeopaths have often tended to reject outright much of orthodox medical knowledge because its ontological, epistemological and practical basis is at odds with homeopathic philosophy³. My decision to choose a lay homeopathic college was based on recognising the opportunity to explore this more extreme perspective in terms of the experience of its student practitioners. Additionally, the nature of the therapeutic practices of osteopathy and homeopathy also provides an interesting contrast to each other. The focus of osteopathy is, to a large degree, on the physical body, for instance, the principles of structural alignment, flow and movement and treatment through structural adjustment. The focus of homeopathic practice, by contrast, is on the homeopathic interview rather than any form of physical touch.

The curriculum is not standardized across different colleges in either homeopathy or osteopathy, and because of this, and the individual histories of each college, they differ widely in structure, content and emphasis. Therefore, it is necessary to be extremely cautious in making any generalisations about professional training on the basis of these case studies, especially on details of the curricula. On the other hand, the value of this study is derived exactly from that uniqueness. As further chapters will demonstrate, the body in training is implicated in uniquely explicit ways at these colleges, and these findings highlight the need in sociology to consider the body in all forms of training and education.

³ My undergraduate dissertation *Challenging Orthodox Medicine? A sociological analysis of the ‘alternative’ theory and practice of homeopathy* (2001) examined in detail the theoretical, practical and social aspects of orthodox medicine and homeopathy concluding that, although many users and some GPs used the two approaches as ‘complementary’, in the many ways they were opposed and so constituted ‘alternatives’.

Describing this study as an ethnography does not simply refer to the methods used for the research, which indeed were virtually exclusively participant-observation at the two case-study settings, but also the epistemological choices and ethical commitments of the research. As many alternative medicines work with paradigms of health and illness that contrast more or less starkly to the dominant biomedical model, it was important to consider how to explore and do justice to forms of knowledge that may be strongly internally validated. Ethnography, with its origins in the anthropological studies of ‘others’, such as tribal communities (Geertz, 1973; Malinowski, 1922), the community studies approach (Banton, 1966; Bell & Newby, 1971; Frankenberg, 1982; Stacey, 1960), and the Chicago School (Anderson, 1978; Bulmer, 1984; Suttles, 1968), seemed an obvious choice for a study of groups of marginalized healthcare professionals. Additionally, simple observation without participation may not have been sufficient for researching a situation where there are alternative and ‘hidden’ forms of knowledge (cf. Lawler, 1991, particularly her discussion of methodological issues in the introduction).

Another factor in the decision to conduct ethnographic research was comparative potential, as previous research on the training and practice of healthcare professionals has often been ethnographic or anthropological in nature (Atkinson, 1981; Becker et al., 1961; Fox, 1992; Fox, 1957; Sinclair, 1997). As Geertz puts it:

if you want to understand what a science is, you should look in the first instance not at its theories or its findings, and certainly not at what its apologists say about it; you should look at what the practitioners of it do (Geertz, 1973: 9).

This, I feel, is just as important for the healthcare professions as it is for ethnography or any other ‘science’. Interviews in this educational context would provide simply

‘snapshots’ of a complex social world, and without spending time in the setting it would be difficult to know who to interview anyway. *Spending time* is perhaps the most essential part of ethnographic research. Over the academic year, I spent approximately 200 hours in each college, taking part in classes, clinics and social activities. The College of Homeopathy ran a part-time course one weekend a month and I attended all ten weekends in that academic year, plus some clinics and tutorials. The College of Osteopathy ran a full-time course and I spent approximately two days a week in college during term time, dividing my time between clinic and classes (see Chapter Three for a detailed description of the curriculum at each college).

One experience particularly reinforced my own view that ethnography was the right choice of research approach. A fellow PhD student in the department, having heard me make a presentation early in the PhD process about my planned study and my interest in the form and structure of knowledge learned in CAM training, approached me afterwards to ask why I was doing fieldwork, and why did I not just examine all the educational texts on the subject. While initially thrown by his question, I was certain that written texts could not begin to capture what happens in training. What I knew even at that stage about the training process for these students was that it involved much more than the acquisition of ‘facts’ but was about bodies, identity and changing ways-of-being. To see knowledge as only text would be to reinforce the mind-body dualism, and to deny the value of the embodied knowledge gained not only through words or books, but also through experience and practice. In addition, seeing knowledge as derived from textbooks limits the possibilities for investigating the development of emotion work skills, such as listening and empathy. The depth of my understanding and my claims to validity lie in my appreciation of the students’ experiences and responses to their course, not just in a comprehensive

cognitive understanding of the ‘facts’ of education in homeopathic or osteopathic medicine.

A final advantage of ‘spending time’ in the setting is the opportunity to develop subtle understandings of the social environment. At the Osteopathy college it was only through informal snippets of conversation and barely noticeable actions, which I only understood the significance of after some time, that I came to realise the extent to which the faculty and, to a lesser extent, the students were divided on the question of integration with orthodox medicine. Even more crucially, I was able to observe that this had a profound effect on the way that the students embodied identities developed in the setting, particularly in relation to professional skills and choices, such as about whether to do postgraduate studies, and, if so, which ones. Again returning to Geertz, it is not enough to hear what people say or write about themselves or their knowledge: ‘Behaviour must be attended to, and with some exactness, because it is through the flow of behaviour – or, more precisely, social action – that cultural forms find articulation’ (Geertz, 1973: 17).

The analysis process used in ethnographic research also motivated my choice of research method. Research is, of course, in the final instance, presented from a single perspective – my perspective – but the strength of ethnography is the multiple perspectives, attitudes, actions and bodies that the researcher is exposed to over time, and then tries to make some sense of. Cultural analysis, Geertz argues, is ‘guessing at meaning, assessing the guesses, and drawing explanatory conclusions from the better guesses, not discovering the Continent of Meaning and mapping out its *bodiless* landscape’ (Geertz, 1973: 20, *my emphasis*). Ethnography can start to unravel the discourses by which a social enterprise is constituted, sustained and reproduced by social actors (Fox, 1999). From fairly general research questions about the form and

structure of knowledge and the development of professional identity, came an informed interest in the social meaning of the healing process through the changing embodiment of the student practitioners, the power relations in the educational environment, and the social values assigned to different ways of knowing and being.

This discussion has explored the value of ethnographic research in the exploration of health care cultures that contrast with the dominant biomedical model, and are, to a large extent, internally validated. The motivation behind the project was to produce a sociological account of the ways that knowledge about practicing osteopathy and homeopathy is re/produced in the settings, and to establish to what extent different methods of healing produce different learning environments and processes. I use the term re/produced to help emphasize the ambiguity between the ideas of being ‘taught’ embodied skills and knowledge and the acknowledgement that in some ways each student must learn these skills from scratch. In addition, re/produced hints at the Bourdieusian interest in the reproduction of legitimated knowledge in the body of the practitioners, rather than just how students relate to knowledge. While I was in the setting much of the motivation came from the people I met, my continued reading on the subject, and my immersion in the setting.

From entering the field to immersion

Reaching a place of immersion in a setting (‘becoming part of the scenery’ or ‘feeling comfortable’) is a long and never-quite-achievable process for the researcher. Events often conspire to remind the researcher of her outsider status. The researcher is part of her setting, and yet also not fully included. She is committed to and constrained by her physical and social environment in the setting, and yet she is also free from the

constraints that operate on its ‘full-time’ participants, and has less invested in the setting. She can theoretically leave at any point. For me, the challenge of entering the field and becoming immersed in it without losing sight of the aims of the research and ‘going native’ was my most significant challenge.

Participant-observation was my key research strategy in the field, following not only the basic principles of ethnographic research, but also because participation in classes seemed to me the most effective way to gain access to the lived experience of the students – experiencing *alongside* them.

The hallmark of participant observation is long-term personal involvement with those being studied, including participation in their lives to the extent that the researcher comes to understand the culture as an insider (Davies, 1999: 71).

Gold’s (1958) classic typology of various roles that a sociologist can take on in the research setting – complete observer, observer-as-participant, participant-as-observer, or complete participant – has remained a useful framework to draw on as it helps to explore not only the degree of access to and acceptance in the setting, and the validity of the findings, but also to remind the researcher of the need for reflexively-monitored participant-observation of the field (cf. Davies, 1999: 72-3). In this research, the shift between these different ideal-type ‘roles’ took place from day-to-day as well as in a more linear fashion as I became immersed in the setting. Joining new classes, or year groups, even after months in the setting, forced upon me the sensation of ‘complete observer’ again as I struggled to get to grips with the expectations and requirements of the situation. Conversely, I experienced the need to consciously drag myself back from ‘complete participation’ at times in order to focus on the aims of the whole experience which was to produce a PhD thesis, rather than gaining a professional

qualification in either of the therapies. At times I felt like an observer-as-participant, for instance in osteopathy 'technique' classes, when the students used me (my body) to practise their techniques on, while I was rarely able to reciprocate because I did not have the necessary experience and skills. At the College of Homeopathy, I spend much of my time feeling like a participant-as-observer because I felt like I *belonged* to two of the year groups and was able to learn alongside them in a more 'authentic' way, while still having different reasons for being at the College.

Taking part in the research settings, I had explicit aims about what kind of data I was trying to collect; however, the practice of ethnographic research demands a large degree of flexibility and the wherewithal to respond to opportunities for unexpected observations. In particular, the kinds of things I was looking to record were (a) evidence of similar and different ways of teaching and learning; (b) the responses of students to different learning contexts and styles; (c) evidence of ways in which acquiring knowledge and skills affects students' identities and self-development and vice versa, and (d) observations made by students and tutors about changing, and not-changing, relationships to others and to their own knowing and being. As well as gaining unexpected opportunities for observations, there were also limits and boundaries to observational opportunities. For instance, at the College of Osteopathy, because of ethical and practical restrictions on observing patients, I had significantly fewer opportunities to observe students actually working with patients in clinic compared to seeing students in discussions with tutors about their patients. I observed about ten consultations, compared to over fifty tutor-student discussions.

The extent of success in sociological practice depends on two aspects of social activity identified by Bourdieu: *practical sense*, or the logic of practice, which is the ability to comprehend and negotiate cultural fields, and *reflexivity* about one's own

practices and relation to the cultural field (Webb et al., 2002: 49). From the moment of entering the field, my passion for the therapies and the people seemed to threaten to overwhelm my commitment to donning my researcher's hat. While the risks of 'going native' were my greatest challenge, evidently, the sociologist in me was determined and the motivation described above remained in place, and my commitment to the field brought significant advantages as well as challenges. I never considered giving up the PhD because it was so important to me, but I did end up enrolling on the homeopathy course after my withdrawal from the field in a researcher capacity. In an attempt to minimize confusion and ambiguity in my role in the field, I refused to make a decision on whether to train as a homeopath while conducting the research, although I knew it was something I would consider doing from very early on. At both colleges I made a lot of good friends, and the student osteopaths especially became part of my social circle at the time and continue to be part of it today. I discuss now each consideration in turn: practical sense, and reflexivity.

Certainly my precarious insider/outsider identity contributed to the extent to which I developed a practical sense in the field. I was able to identify with the aims and commitments of the participants. Crossley notes, drawing on Bourdieu's logic of practice:

The sociologist must approach each social field as if approaching a new game for the first time, attempting to discern the point and the sense at work within the hurly burly of practice (Crossley, 2001: 101).

However, for me, this was not a 'new game' but one in which I was already personally and professionally involved. My previous experience of CAM as a user, a

researcher, a practitioner⁴ and as the daughter of a homeopath⁵ served me well in aligning myself with the participants as a friend rather than an enemy from the outset. From an ethical point of view my commitment to the field acted as a buffer to any serious ethical conflict of interest. It also reassured participants that I was unlikely to willingly misrepresent them. At both colleges my identity as a student was probably the most important, although for different reasons. (See Chapter Four for a full description of the age, gender, class and ethnicity breakdown of the students at the College.) At the College of Homeopathy, my student status brought respect (being from a good university) and ‘maternal’ support as the older women, some of whom had children at university, were keen to encourage me. At the College of Osteopathy, my student status aligned me directly with the students. Discussions of ‘too much work’ and ‘not enough money’ were most common.

At the College of Homeopathy, gatekeeper access was granted very easily by the principal of the college. She was very interested in the research, and felt that, with the ongoing debates about the development of a single register for non-medically qualified homeopaths and possible government regulation, it would be an ‘insurance policy’ to have someone studying the college. Her only stipulation was that I should spend all of my first day in the field with one first year group. She did not really explain this, but I understood that this was to enable the group to bond effectively on the first day of the academic year without the uncertainty or disruption of someone coming and going. This turned out to be incredibly productive for the research as I did feel part of that group, as well as a third year group that I also joined and regularly

⁴ I have trained as a Reiki Master Practitioner, have taken courses in Thai Massage, Flower Essences, Transcendental Meditation, Kung Fu and Qi Gong, and have practised Yoga Asanas since I was twelve.

⁵ My mother started working as a regional tutor for the College of Homeopathy at the same time as I started the research. She also began working part-time at a private clinic around the same time alongside some osteopaths who taught at the College of Osteopathy (although I was unaware of this link when I first approached the College about the research).

spent whole days with. The trust that I had from the principal and the members of the group served to open up many areas that might otherwise have remained elusive, and my membership of the group as a participant as much (I felt) as an observer facilitated the process of gaining a practical sense of the dynamics and internal ‘logic’ of the setting. Because of the ease with which I was granted access to the College, an enormous amount of trust was placed in me not to misrepresent the College, its staff or students. I was initially surprised by the ease with which access was possible because homeopathy has a chequered history with ‘scientists’ and ‘researchers’ who in the main have sought to discredit the profession, but the presentation of my project as being interested in ‘how do people learn to practise?’ (rather than ‘does homeopathy work?’) was clearly not seen as threatening.

I never gained written consent from the students at the College of Homeopathy, but because of the organisational set-up it was extremely easy to be sure that I had contacted all the students to explain my research and get verbal consent. I was able to approach classes, explain my research, then leave the room as they discussed if they were happy for me to participate in their group. It was my experience that the response I got from groups was invariably enthusiastic. The first year group that I joined on the first day were given an opportunity at the end of that day to discuss any concerns with me and the principal that they had. Apart from a few questions about confidentiality few concerns arose. Part of this I hoped had been my self-presentation and my explanation of what I was doing. There is a huge amount of emphasis at the College of Homeopathy about ‘being on a journey’ – this was something that seemed to be understood from the beginning – and I explained that my research was a journey as well. I was honest about my motivations in doing

the research, both personal and academic. I have no doubt though that the principal's enthusiastic support was vital too.

At the College of Osteopathy, access was more of a challenge. The argument that access must be continually renegotiated at every stage of ethnographic research (e.g. Hammersley & Atkinson, 1995: 54) became a lived reality that caused me a fair amount of stress. While initially I thought that I had gained access relatively unproblematically through senior administrators and academics, I soon found, after some early observations mostly with first years and at a few student clinics, that I had exposed some 'raw nerves' in the organisational set-up and power relations within the College, and I ended up having to clear my research with many departments individually. As one member of staff put it, 'The line stops with me in [this area of the college] so I thought I should talk to you... your research has been causing some angst in the faculty'. Much of the problem lay also in the pressure that certain members of the College felt to demonstrate equally rigorous procedures as orthodox medical ethics committees as the profession became more allied with the orthodox system. A few altercations later with various members of staff, some more public than I would have liked, I managed to achieve a precarious agreement to access after a 'chat' with the senior research staff. In the end, my success at securing access came, I felt, because what I had to offer the College was more peer-reviewed published work on osteopathy, which fitted in with the College's own goals. These experiences that challenged the possibilities of access to the osteopathy college do not form part of the data directly presented for analysis in this thesis, but were significant for my general understanding of the functioning of power relations in the college (see Burgess, 1984 on the link between access and knowledge about the field).

Having committed to the College of Osteopathy as my case study, and with some strong support within the faculty and discussion with those who initially had a more suspicious response, I decided that having got access to the building, I would pursue my access to what I was interested in finding out through the students. I was interested in their lived experience, and so I realised that they were the real gatekeepers. I approached a second year group, explained what I was doing and asked them to give me written acknowledgement of their consent to participate in their classes. Similarly, I approached a clinic group (consisting of a mixture of third and fourth year students) and got written consent to participate in their clinics. Because the College of Osteopathy was a much larger organisation with many unfamiliar faces, it was only once I became familiar socially with many of the students, that I started to 'feel comfortable' and be recognized by students as 'part of the scenery'. My development of a 'practical sense' of the workings of the College began to mean I could form meaningful, contextualized opinions and conclusions about aspects of college life and embodied experience. In the end, much of the observation that I did happened outside of the situations of 'written consent', through being invited to join classes and clinics by staff and students, through informal chats over breakfast or lunch, at the pub after college or in the library between classes. The second year class particularly 'took me under their wing', inviting me to social events, allowing me a deeper picture into the kinds of resistance to the college system that I could not gain through observation and participation in classes alone.

Informants are understood to be vital to any ethnographic research, and at the College of Osteopathy, particularly, my various informants gave me insights into the multiplicity of insider perspectives on the College, and particularly the contrasting 'pro' and 'con' opinions on the changes in the curriculum towards teaching a model

of osteopathy that was more readily integrated with orthodox medicine. And perhaps because of this underlying professional dispute, these informants often selected themselves (cf. Davies, 1999: 78), to show me aspects of their world, particularly things they felt it was important for me to know. Although in most ways I was closer to the students, I often had a privileged access to the staff, and they confided in me. Often these things are a matter of personality, but sometimes I got the feeling that participants felt that an ‘outsider’ would better understand, or sympathize, with their discontents. Similarly, students wanted to tell me things about their opinions of certain classes or tutors, or they would want to show me things that they thought would be useful to me. For instance, one student wanted to show me the old osteopathy books (early 1900s) in the library that presented a much wider scope for osteopathic treatment than that encouraged by the College⁶. I was, indeed, interested in this despite already being aware of the narrower therapeutic remit officially encouraged by the College. The active realization within the student population of the silencing of aspects of osteopathic ‘history’ provided me with additional insights to the production and reproduction of osteopathic knowledge in the College, and the student’s experience and negotiation of the course.

This also had implications for aspects of the training that I had access to. For instance, the research staff were not keen for me to observe students working with patients. However, when I explained this to certain clinic tutors, they would say things like, ‘But that is so fundamental to what we are teaching here.’ Another tutor said that he was unhappy with the idea that I would be doing research but not observing teaching with patients, ‘I’m the osteopath in charge of the patients, and they [the patients] know there will be people observing... it is important that you see that

⁶ The College encourages referral to GPs for a number of diseases that ‘classical’ osteopaths consider to be well within their therapeutic remit.

there are different ways of doing things here.’ The tutors and students took responsibility for which patients I could go in to see, and I was introduced as a ‘colleague’ to the patients. The patients, who know that they are coming to a teaching clinic, were invariably indifferent. In general, I found in the osteopathic clinic that I lacked control over my interaction with patients. The osteopaths were not prepared to consider explaining to their patients that I was a researcher because they felt it could make the patient feel unnecessarily uncomfortable and they explained that the patients were already aware that there may be other people observing (although this was presumably expected to be other students or staff).

My situation mirrored Atkinson’s study of medical training with respect to my lack of power to define myself to patients. Atkinson justifies this by saying that he felt he would be questioning the position of the doctors if he were to disclose his identity when clinicians remained silent. Hence he argues that in his case covert observation of patients did not reflect his superior power, but rather his inferior position. Control, he argues, is given up in naturalistic research (Atkinson, 1981: 135-7). I do not accept that it is that simple because by making his initial contact through the management of the hospital, he was placed in a position of power above that of the patients. For him, as for me, this was by far the most practical and appropriate method for gaining access given his research subject, but is by no means the only route of access to the hospital setting. In her study, *Behind the Screens* (1991), Lawler did her initial fieldwork when visiting a friend who required major surgery. Only later did she approach management. However, as Lawler points out, ‘as long as there is some separation in the role of researcher and subjects, the gathering of information will inevitably have some hidden aspects even if one is an openly declared observer’ (Lawler, 1991: 143).

I justified my decision to remain a covert observer of the patients in the osteopathic clinic on four grounds. Firstly, to explain to every patient that came into the clinic that I may be listening into conversations about their case (even if not observing directly) would have been unworkable, and patients were already aware that they were attending a teaching clinic and may be observed by a number of people. Secondly, my interest was not in the patients *per se* but in the student-tutor teaching interaction and how students were learning embodied skills. Thirdly, the patients were entitled to the same *confidentiality* offered to them by the students, so I have ensured that none of the patients can be individually recognized. Finally, although at times I felt uncomfortable that different members of staff at the college had different views on it, it was the clinic staff and students who had direct responsibility for the patients and who ultimately made the decision, which was the only *practical* method.

This self-conscious mode whereby staff and students were ‘informing’ me was facilitated at both settings by the ‘reflexive turn’ that has moved from academic research into the world of medicine and healthcare training in recent years. The ‘reflexive turn’ in contemporary sociology and anthropology has ensured that researchers are required to recognize and reflect on their impact on the research. Illusions of detachment and objectivity have been criticized, and sometimes redefined, from many quarters but perhaps most notably in feminist research, where the commitment to feminist ethics and research ‘*on* women, in research carried out *by* women who were feminist, *for* other women’ (Stanley & Wise, 1990: 21) has been incredibly influential. As Stanley and Wise explain,

Our position is that *all* knowledge, necessarily, results from the conditions of its production, is contextually located, and irrevocably bears the marks of its origins in the minds and

intellectual practices of those lay and professional theorists and researchers who give voice to it. The existing discipline of sociology is neither neutral nor impartial; it reflects the practices and knowledge of groups of highly particular white, middle-class, heterosexual men while seemingly reflecting universalisms. Its sexism is no 'intrusion' or 'mistake' (1990: 39).

Wacquant, following Bourdieu, argues that we are not 'free floating': 'reflexivity is precisely what enables us to escape such delusions by uncovering the social at the heart of the individual, the impersonal beneath the intimate, the universal buried deep within the most particular' (1992: 44). Drawing on recent ethnographic studies of the workplace and Bourdieu's social theory of practice, Adkins (2004) points out that the idea of gender as a taken-for-granted characteristic of workers is being replaced by a more routinely reflexive approach. This, she argues, in contrast to the objectivism of writers such as Beck and Giddens 'leads, therefore, not to an objectivist reflexivity, but to a situated reflexivity, a reflexivity which is not separated from the everyday but is intrinsically linked to the (unconscious) categories of habit which shape action' (Adkins, 2004: 195). Reflexivity is being increasingly considered in academic studies of healthcare practitioner training (Atkinson, 2000; Good & Good, 1993; Phillips et al., 2002) and methodological reflections of ethnographers are being published more frequently (Birch, 1998; Cant & Sharma, 1998; Phillips et al., 2002; Skeggs, 1994).

In addition, concerns with 'reflective practice' in many healthcare professions have brought about assessment through 'reflective portfolios' and other modes (e.g. Driessen et al., 2005; Droege, 2003; Eraut, 2004; Heath, 2004; Phillips et al., 2002). As Chapter Six will explore, by examining the student-practitioners' experiences of working with 'real' patients, reflexivity is by no means exclusively the domain of the sociologist. From a methodological point of view, it is clear that the informants in my study were keen, as Rabinow puts it, to 'spend [...] more time in this liminal, self-

conscious world between cultures' (1977: 39) which was facilitated by my role in the setting *qua* researcher. The informal nature of much of my interaction with participants meant I often had the opportunity to describe in some detail what my research was about. The ways in which my explanations were picked up, commented on and interpreted by the participants offered additional insights. In the main, participants seemed really interested in the research questions, asking probing questions, and offering their opinions. I got a lot of positive feedback at both colleges from people I discussed my research with in detail, both about the subject and about my participation. I was commonly told that I asked good questions, which illustrated that what I was doing in the setting was not only observation of 'authentic' action, but often an informal form of interviewing trying to elicit specific reflections from my participants. Tutors from the homeopathy college often asked about the research and commented on aspects of my participation in classes. Discussing my research was also an ethically informed decision to ensure that participants did not completely 'forget' my researcher role as I became more immersed in the setting. The frequent questions and interest I had from participants confirmed that they had not forgotten.

The informal nature of my interactions was also reflected in the way that ethical issues were approached and discussed. In the osteopathy student clinic, during a discussion about a patient that I had observed the student working with, the tutor asked me what I thought of the case. I gave a short response saying that I felt that the student's assessment was good, partly because I did and partly because I felt it would be inappropriate to offer any more critical assessment in the context. However, afterwards I talked to the tutor and explained that I felt unsure about how involved I could or should get in case assessment and analysis. She asked me whether I would report it if I saw something going wrong and causing harm to a patient. I responded

that I would if it was something serious like that, but that the more difficult question was whether I should intervene if I could see some way to improve treatment. In classes, I explained, it was possible to contribute or ask questions, but this was more problematic in the clinic environment where real patients were being treated. We discussed it and agreed that it was a grey area, but that it was probably inappropriate to make any suggestions or comments in front of the patients. My ability to take part in conversations about ethics in this informal way reinforced the feeling that I was developing a practical sense in the setting because I could judge the appropriate tone and nature for such conversations.

The development of practical sense was mediated most fundamentally by reflexivity. It was only through reflection that I realized 'how far I had come'. The practice of reflexivity was important academically, practically, and ethically during this research, from all stages from access to immersion. For me, so much of keeping on top of reflexivity came from writing in my research diary – anticipation of and responses to certain situations, keeping track of my opinions and perspectives and 'checking in' with what I felt about the research, the colleges and the participants. Certainly, reflexivity gives some control over the day-to-day ethical dilemmas that the researcher faces, particularly when the unexpected happens. However, reflexivity is an ongoing process that affects all aspects of my life (maybe especially because I come *from* a place of sociological embodiment?), but during the research writing became a way to process, formalize and record it both for future reference, and to ensure that it modified my actions as appropriate.

For instance, the way I introduced myself and my research changed over the time I was in the setting. As I became more familiar with the kinds of responses I would get I modified my self-introduction accordingly. In order to monitor this, its

implications and to make explicit what it was that I had *learnt* about the setting that had motivated the change, I kept a record of the kind of things I would say. For instance, I took to not using the term 'alternative medicine' in my introduction while at the College of Osteopathy, as it sometimes engendered negative responses, such as 'we are specialists' or 'we are complementary' which served to put up barriers. I would try to establish the person's point of view on the issue, rather than (unintentionally) placing myself in a category that favoured any particular term.

Another issue that came up a few times was whether I should wear a white coat in the student clinic at the College of Osteopathy. On my first visit to the clinic, I was 'offered' a white coat in a way that I was not expected to refuse, and the tutor found me a vastly oversized one, which ironically highlighted my outsider status anyway. On later visits, however, I began to resist the assumption that I would wear a white coat as I felt that it caused more confusion and ambiguity than was necessary. (See Chapter Six for a full discussion of the wearing of white coats.)

Language is a vital component in ethnography. In traditional anthropological studies, the ethnographer usually needed to learn another national language, and in studies of institutions, learning anatomical terms, technical language or organizational acronyms are vital. However, in the study of interaction, verbal communication is often privileged over other forms of communication which are at best alluded to. Gleason's (1989) study of residential homes for people with severe developmental disabilities is an example of how focusing on observation of embodied actions and behaviour rather than spoken language can bring about insightful analysis of a situation. Reflecting on my ability to 'fit in' bodily as well as with my language in the setting was vital. In terms of language, I realized sometimes that I was 'in on jokes' that I would not have appreciated when I first entered the field, or I would find

myself *not* asking things that I might have sought an explanation for previously. I would find myself responding to situations in an ‘appropriate’ way that through writing and reflecting in my research diary I knew would not always have been my response in other settings. For instance, there was a fascinating example of a discussion of an ex-College of Osteopathy student who had managed to graduate but was later struck off. He apparently told patients that he was ‘removing pixies’ from them. This caused much laughter in the group and disbelief from me. On further discussion, I eventually managed to get the tutors to explain that they did not necessarily think that what he was doing was bad, or even ‘ineffective’, but that this language for describing his healing work was not ‘appropriate’ in the osteopathic environment. This also explained my disbelief, because I evidently had made the ‘strange familiar’ and understood how to ‘play the game’ at the osteopathy college. In doing this, in a natural and spontaneous way, I understood that this was not acceptable language to use and it was OK for me to laugh.

Similarly, especially towards the end of my time in the field, I began to be able to recognize the differences in the ways that the two professions would approach a case. I had developed new ways-of-seeing and -listening to the body alongside the students. Sitting in osteopathy classes I could see what was different about how homeopaths would analyse the cases. I could see the connections that the osteopaths would ‘miss’ or would not see as relevant. And vice versa, in the homeopathy classes, I would recognize that the depth of familiarity and intimacy with the physical body that the osteopaths took for granted was absent and had to be more consciously negotiated. These ways-of-listening to the body (described in Chapter Four) are now part of my way-of-being with others and I find myself today wanting to put my hands on parts of my friends that hurt (my osteopathic body) and wanting to point out

connections between my friends' symptoms that they may not have thought about before (my homeopathic body). There were also situations where it was necessary to participate in an explicitly embodied way, such as in Chi Kung classes at the College of Homeopathy, and in technique classes at the College of Osteopathy. I felt that this participation could not be 'faked'; it was necessary to absorb at an embodied level the impacts of these aspects of the training, and my growing familiarity with these activities that initially I often experienced with difficulty or with a sense of clumsiness (cf. Leder, 1990) contributed to my understanding of the lived experience of the students.

Academically, it is now a standard to accept that reflexivity is vital to social science research practice. Drawing on a quote by William James, Frank states:

To settle the Universe's hash is to place oneself outside the vulnerability and contingency that being in the Universe involves. The intellectual infected with such an ambition ceases to think of himself as a body, thus disclaiming the vulnerability that bodies share... Social science – or any academic and professional discipline that observes and attends the ill – must accept responsibility for its observations as acts of witness that commit the scientist as a person (Frank, 1995: 19).

I argue here that it is important to recognize the epistemological implications of this. In my research, I was constantly being exposed, in a learning environment, to new ways-of-seeing the body and new forms of knowledge, and I was having new experiences and learning new things about my own body, emotions, and spirituality. Once these new ways-of-being had been explored and experienced, my body registered it and there was no 'going back'. The impact epistemologically of 'incorporating the research' is not superficial. As the examples above show, doing

this research fundamentally changed the number of ways I was able to interpret the dis-eased body. The production of the written product of research is from the embodied researcher that I am today, and not from where I started out. There are no objective tests or measures, but simply a sociological perspective, albeit an informed one, on the Colleges that I was part of for an academic year. Therefore, in terms of analysis, the research data and this thesis must be understood to be produced from a socially and temporally located embodied perspective. In this way, reflexivity comes into its own: the constant shifting of the researcher's habitus means that it is problematic to make assumptions about the setting, to impose one's own interpretations on the participants and their social world. However, interpretation and analysis is what the sociologist does, therefore, the requirement for careful and reflective observation, listening and embodied participation, as well as verbally confirming the nature of others' experiences in similarity or contrast to one's own when practicable is key.

Practically, reflection on my day-to-day experience, during the writing of my research diary, drew me back from the world of experience to the world of sociological analysis, and prevented 'going native'. A key part of this thesis is to explore embodied knowledge, but this is not something that is easily expressed in words. In some ways, reflexivity (as conscious reflection on experience) is somewhat inimical to experience. You can not feel fully and think about feeling at the same time. The challenge I faced, alongside the students, of 'getting out of the head and into the body' (a phrase used by various homeopathy tutors) was limited by the need to constantly return to sociological thought and analysis. Reflexivity emerges as an embodied skill in the context of learned professional sociological skills. It is a way of being-in-the-world that affects all aspects of the sociologist's life. The distinction

between personal and professional skills is somewhat arbitrary. I certainly find it incredibly difficult to switch off my sociological gaze even when I am not working.

As noted above, my research was mostly non-covert; all the students and staff knew who I was and why I was there, but at times my participation was virtually full. In particular, at the College of Homeopathy, participation in Personal Practitioner Skills classes, Energy Work and Shamanic Journeying involved being witness to people's emotional displays and personal issues on a large number of occasions. Sharing 'energy' and 'witnessing emotions' (ideas which are explored more fully in later chapters) were integral parts of the learning experience for students, and so also important for me to observe and participate in for the research. Nonetheless, ethical issues of confidentiality and exploitation are clearly relevant. I could assure the confidentiality of my participants, but it was more problematic to argue that they were gaining anything particularly from my presence, which was so important for my PhD and future career. Indeed, the potential for exploitation is particularly high – and I knew that I had gained trust from the participants not to misrepresent them – in these settings where professional identities and qualifications do not hold the same cultural value as comparable professions such as medicine. What I can say is that in participating in these classes I was learning, alongside the students, the skills of listening and witnessing, which served only to deepen my empathy and research skills. I quote here at length Arthur Frank on ethics, because he expresses so clearly some of the values I deepened while doing this research:

One of our most difficult duties as a human being is to listen to the voices of those who suffer. The voices of the ill are easy to ignore, because these voices are often faltering in tone and mixed in message, particularly in their spoken form before some editor has rendered them fit for reading by the healthy. These voices bespeak conditions of embodiment that most of us

would rather forget our own vulnerability to. Listening is hard, but it is also a fundamental moral act; to realize the best potential in postmodern times requires an ethics of listening. I hope to show that in listening for the other, we listen for ourselves. The moment of witness in the story crystallizes a mutuality of need, when each is *for* the other' (Frank, 1995: 25).

I certainly developed a lasting friendship with many of my participants, an idea that is supported by feminist interviewing principles (Oakley, 1981), and offered them advice and support on a number of occasions, using skills I had both brought to the field and those I had learnt by participating in these colleges.

Inscription and expression of experience

'What does the ethnographer do?' – he writes (Geertz, 1973: 19).

Writing is fundamental to academic research as it is the prime mode of dissemination, discussion and debate of theories, methods and findings. For me, writing offers a way to process my experiences, my feelings and my ideas. It is a way of focusing and deepening my understanding. For this reason, the physical act of writing – of committing words to paper – is key to the analysis process. To be part of a culture is not necessarily to be able to write of it, because to write of it is in itself an abstraction and signification of that culture and involves analysis and interpretation.

Geertz argues that ethnographers write about culture, more precisely he argues that they write 'thick description':

As interworked systems of construable signs (what, ignoring provincial usages, I would call symbols), culture is not a power, something to which social events, behaviours, institutions, or

processes can be causally attributed; it is a context, something within which they can be intelligibly – that is thickly – described (Geertz, 1973: 14).

Patterns of behaviour in cultural settings can not be defined as ‘laws’ or ‘rules’ in the sense that the physical sciences use those terms. Bourdieu’s use of the term ‘strategy’ encapsulates this idea well:

The notion of strategy is the instrument I use to break away from the objectivist point of view and the action without an agent that structuralism presupposes... One’s feel for the game is not infallible; it is shared out unequally between players, in society as in a team... The habitus as a feel for the game is the social game embodied and turned into a second nature. Nothing is simultaneously freer and more constrained than the action of the good player (Bourdieu, 1990a: 62-3).

In this way, writing of ethnography is one form of interpretation and expression of the cultural settings and experiences that I (in an embodied sense) have been witness to and part of at the Colleges. The ‘final’ version, therefore, is an interpretation from who I am today; it is inherently partial (Clifford, 1986). Undoubtedly, the volume of data that I have collected over the academic year spent in the two colleges will serve as data for future re-interpretations for many years.

My experience of doing the ‘writing-up’ was one of friction between trying to stay true to the internal dynamics and values of the setting (that I experienced and came to embody to some extent) and the sociological dictates of writing that require analysis and at least a semblance of order. The solution, to the extent that a solution is possible to two largely competing interests, was to write different drafts – my first drafts were more like data drafts – imagining myself back into the setting, re-feeling the sense of immersion and commitment to the field that I felt – and writing *from* that

body. Then subsequent drafts, especially after comments from supervisors, incorporated a more critical approach. By then also my distance was greater from the field in terms of physicality and time. My commitments had shifted between gaining an understanding of the setting that did justice to the passions and commitments of those involved in it, and my own passion, commitment and investment of various kinds (emotional, mental, financial) in producing a piece of writing that met the requirements of a PhD. It was easy to get lost in this academic and theoretical place, and so to be able to return to the data and the field was vital in preventing the loss of the feel of the settings and the passion and lived experiences of the participants. Partly because of this friction, this thesis explores key aspects of the settings as a *whole*. Future publications may take key sociological concepts and explore those in more detail drawing more selectively from the data.

Writing field notes is a key tool for the ethnographer, and the first level of analysis. Keeping my research diary was my way of interpreting and committing to memory aspects of what had happened, what it had felt like, and what I thought about it. Because my fieldwork was in an educational setting, it made note-taking much less conspicuous. It rarely interrupted the flow of action in the settings, although sometimes I would have to escape to the library to catch up on what I had observed, or make notes on the train home. In contrast to Atkinson's experience of doctors where 'there seemed to be a cultural requirement that cases should be presented at the fastest possible speed, with facts and figures fired at the recipients with little or no hesitation; indeed with very little variety of intonation, amplitude, stress etc.' (1995: 11), in my settings tutors' pace and delivery were quite reasonable, even within clinic work. In classes and lectures obviously the pace was slower so that students could take notes.

On a number of occasions participants would ask me what I was writing about, and whether it was different to their notes. I tended to explain it by saying that I was writing not only the key points about what was being said, but also the ‘in-betweenness’ – that is, how things were said, the tone and actions that affected how the material or ideas were being presented. Of course, this was based on an assumption of what the other students were making notes on, but the explanation was accepted. Other important things to consider when observing are lighting, colour, smell, sounds, temperature and the arrangement of objects in the room (Bailey, 1990). My notes, then, are not ‘transcriptions’ of what happened in the setting, although many of the comments were recorded verbatim as I was sitting in classes with a notebook. But often spoken words or impressions were written down a few minutes or hours later, even occasionally the next day, especially in settings such as technique classes at the College of Osteopathy where the students rarely used notebooks and I felt that using mine would be unnecessarily conspicuous. However, much of the importance of these classes for the research was in what was happening, in what was been done, not what was said, so the context and narrative description written up after the class was, I felt, more than sufficient. Lofland and Lofland (1984) suggest that for every hour of observation, the researcher should produce about thirteen pages of fieldnotes, so they certainly can not all be written at the time. I do not claim to have managed that for every hour of observation, and certainly as the research went on and I became more familiar with the setting this was less necessary. Nonetheless, going over and making additional notes after observations provided an opportunity to make analytical memos, which facilitated the reflective process:

The construction of analytic notes and memos... constitutes precisely the sort of internal dialogue, or thinking aloud, that is the essence of reflexive ethnography... one is forced to

question *what* one knows, *how* such knowledge has been acquired, the *degree of certainty* of such knowledge, and what further lines of inquiry are implied (Hammersley & Atkinson, 1995: 192).

Analysis is not a distinct phase in research (Hammersley & Atkinson, 1995: 205), and the layers of analysis developed and shifted as the research went on. Later events forced re-interpretation of previous ones. Events that at the time I had not noticed enough to write down would come back to mind in light of new observations. The idea that research design and analysis is an iterative process was explored most famously by Glaser and Strauss (1967), in their book *The Discovery of Grounded Theory*. This has been criticized by many because it denies the effects of influences that any researcher brings into the field, such as that from previous experience, cultural expectations, and other published work in the area. Nonetheless, the ethnographer rarely has a clear idea of what s/he is going to find out about when entering the field. Important themes *emerge* from the research.

In the analysis process I explored a number of themes and ideas that had come up during the early stages of analysis during the data collection period. Eventually, I decided that it would be best to sort my data into four sections: (i) curriculum overview and general observations about types of teaching and learning opportunities during the course; (ii) the student's experiences and negotiation of the staging of the learning process and assessment; (iii) the learning of 'theory' in classroom settings, and (iv) learning to deal with 'real' patients in clinic settings. This enabled me to divide the data into more manageable chunks while retaining the internal narrative integrity of specific observation periods in order to avoid unnecessarily 'de-contextualising' the data. Within these more broad distinctions, I went on to further

analyze the data identifying themes and patterns as well as inconsistencies and unusual cases.

Understanding the role of writing in the development of ideas and thoughts can be illuminated in the context of an embodied understanding of sociology. Writing is, as noted above, a form of abstraction and signification of experience. However, the aim of this thesis is to be able to capture, to some useful degree, the embodied aspects of experience, which are by their very nature, difficult to capture in words, particularly for the ethnographer who has become a kind of insider to the setting. As Bourdieu notes, ‘what is “learned by the body” is not something that one has, like knowledge to be brandished, but something that one is’ (Bourdieu, 1990b: 43). Once the body becomes ‘absent’ (Leder, 1990) it is even more difficult to capture what is ‘known’ in words. Barrett (2000) notes that there is a risk that the sociology can become ‘boring’ because by retaining the cognitive style of the medium (academia), the sensuality and passion of the field could be lost. She argues that if sociology is to ‘wake up, it needs more humanity, it needs more imagination, it needs more perception, it needs to appeal to experience beyond cognition. It needs more respect for other ideas on their own terms, not translated into its own’ (Barrett, 2000: 20).

Creswell argues that a vital part of ‘good ethnography’ is that ‘the ethnographer makes explicit what is implicit and tacit to informants’ (1998: 212). With a concern for embodiment, this is even more important as the body tends to be devalued and silenced in our culture. To write of embodied experiences it is important to notice and make aware where there are absences of language (silences) to describe what is going on. By listening to the words and actions of those practitioners for whom the body is their daily focus, we have the opportunity to

deepen our understanding of human experience, and in this specific research, the nature of human learning.

Writing as a woman is not easy to do in academic circles, as Devault explains:

Rhetorical processes – like all social interactions – are deeply gendered. Speakers and listeners produce and respond to statements on the basis of deep but usually unnoticed understandings of gender. In general, women’s right to speak (or write) authoritatively is attenuated and circumscribed. For a women to do scholarly work means speaking in the manner of the disciplinary tradition. They learn that, if they are to be heard, their text must enter a discourse whose contours reflect male perceptions and concerns. The readers whose judgements are influential – the teachers, the editors, reviewers and colleagues who will incorporate and perhaps extend their work – have, in the past at least, mostly been men (Devault (1990), cited in Hammersley & Atkinson, 1995: 254).

However, some women have challenged this by writing about the body and emotions in innovative ways. Probyn’s (2004) fascinating reflection on shame in the habitus explores the problems that sociology has with the body and how they can be tackled in academic work. Even Bourdieu’s work, which is often cited as exemplary embodied sociology falls short, she argues. ‘In terms of distancing the body’s physiological and emotive unruliness, Bourdieu’s habitus is repeatedly brought in to make sure that we know that it is the social that rules’ (Probyn, 2004: 236). Social scientists often fear the trap of ‘biological reductionism’ or extreme methodological individualism when they begin to talk of the physical body. Sharma (1996) critiques Scheper-Hughes’ (1988; 1990) work on the somatization of mental states by pointing out that although it goes a good way to bringing the body back into social action ‘she pulls back at the last moment... I am then disappointed by her use of the term “using” as though bodily distress is a ploy, a technique by some person who is located

inside the body but for whom the body is a mere tool of communication rather than part of the she or he who communicates' (Sharma, 1996: 257-8).

The inability to express embodied experience through language may be part of the problem:

Maybe this is a matter of language, the poverty of English in providing ways to convey the relationship between body and social self as other than subject and object, the difficulty in expressing the possibility that bodily states might relate to the social states without being reduced to an instrumental 'expression' of them (Sharma, 1996: 258).

Certainly, it is a challenge to the social scientist to explain with words that which is taught without. One of the tutors at the College of Homeopathy suggested to the students, 'Sometimes I struggle to find the right words to explain what it is that flower essences do. We need to find a new vocabulary. Maybe that could be your gift.'

Various feminist writers have tackled this issue of language and meaning, suggesting that women should access their connection with their body and use it in their writing. Helene Cixous argues that writing need not be limited by the 'history of reason', that writing is a way for woman to get back in touch with her body, 'giving her access to her native strength' and to be subversive by 'break[ing] up the "truth" with laughter' (Cixous, 1991: 225, 229). Wilshire suggests that women should let their bodies take the lead in new ways of learning:

that we employ different methods of looking at data; that we analyze it differently and from a new perspective - our own... that we seek a different PATTERN in it, utilize *different kinds of consciousness*, and learn to go from one to the other at will; that we learn to listen with empathy when we have been taught only to look with detachment; and that we employ ways

of thinking and seeing that for the most part have been excluded from western science and epistemology' (Wilshire, 1989: 109, *emphases in original*).

Certainly ethnography remains one of the areas of academia where expressive language, metaphor and anecdote have survived as conventional form, and have not been 'killed by science' (Pratt, 1986: 32).

Another problem to be considered is the validity of 'speaking for' the participants in the study. In writing the ethnography, I am drawing together multiple perspectives into a single text arranged in a way that I believe most accurately represents the setting and best provides a good structure for sociological analysis. Kreiger's (1983) monograph of a lesbian community tackles this problem by combining a stream-of-consciousness style speaking from different members of the community that melds together fiction styles and social science. Alternatively, trying to use direct quotations as much as possible, and providing detailed examples that aim to preserve the original context and tone of interaction may go some way to tackling this. Additionally, I must make clear my own contributions to social interaction in the settings by not editing out the personal voice in my writing.

As Atkinson points out, how one writes an ethnography does not and cannot totally determine how it is read. 'We read, and read into, the text, based on our own background knowledge and assumptions' (Atkinson, 1990: 2). Part of my skill then as a writer of an ethnography, is to make clear my own interpretations while organizing my textual representation of aspects of the students' experiences in such a way that it facilitates the reader's own internal process of analysis. Realistically, not all potential strands of discussion, debate and comparisons can be tackled explicitly in the analysis, and if they were to be it would quickly become tedious and repetitive. However, the 'rich' description of the ethnography should permit the reader some

access to the ‘feel’ of the settings, so that they can imaginatively transport their own bodies into the midst of the activity.

Certainly, it is now widely recognized that the process of writing is vital in the construction of ethnographic, indeed any sociological, research. However, Hammersley and Atkinson assert that,

There is no more damaging myth than the idea that there is a mysterious ‘gift’, or that writing is a matter of ‘inspiration’... [such views] inhibit systematic reflection on writing (and reading) as necessary aspects of the disciplinary or craft skills of social scientists (1995: 239).

Clearly Hammersley and Atkinson are right that writing is a skill that should be developed and valued in the ethnographer. Perhaps they fear the relegation of writing to a ‘natural’ skill much like ‘caring’ with nurses, who had a huge struggle to get the value of their skills recognized. Nonetheless, something is missing here in their analysis, because the *experience* of trying to write ‘feeds the myth’. Days can go by where the writer feels nothing of worth is being inscribed – writer’s block sets in. It can be frustrating and depressing. Then, suddenly, everything is OK again and the words tumble onto the page (or computer screen). Writing then is an embodied experience, a social experience. The ‘inspiration’ may not be divine, but the product of a set of suitable circumstances, environmental, personal, emotional. For me, the most important thing is ‘having my own head-space’ so that I can concentrate, i.e. minimizing the negative influences of my body-in-the-environment – so I need to make sure I have had enough sleep, no hangover, a quiet environment, and am in the midst of no emotional crises.

Conclusion

To conclude, then, the research process is a way of constructing knowledge about the world that we live in, but knowing is not separated from the knower and so, as Jaggar argues, ‘The reconstruction of knowledge is inseparable from the reconstruction of the self’ (1989: 164). This chapter has explored my experiences of doing ethnographic work at training colleges for osteopaths and homeopaths. Through exploring motivation for the study, access and immersion in the field, and the writing process, I have elucidated where my research touched and negotiated issues related to the ethics and politics of doing research. By ‘spending time’ and becoming immersed in the setting, I developed a practical sense of the setting which supports the validity of my findings. Being committed to reflective research practice, I avoided the potential pitfalls of ‘going native’ despite an interest and commitment to the field. During the research, I began to appreciate the extent to which embodiment is fundamentally implicated in any learning process, including mine and that of my participants. This research, therefore, provides insights, with a focus on embodiment, on the social meaning of healing practices, and the values attached to different ways of knowing the body and embodying knowledge.

THREE

Sketching the field: the case studies

Introduction

While Chapter Two explored the motivation for the choice of case study therapies and colleges, this chapter provides a more detailed introduction both to the therapies under consideration – osteopathy and homeopathy – and the individual colleges that are the subject of this research. The different histories and development of the therapies are crucial for understanding today’s teaching and learning, so this will be explored first, drawing on debates raised in Chapter One. Then, the chapter will turn to a description of the curriculum, organizational set-up and environment of each of the colleges, and consider the values espoused by the college in relation to the therapy and their ways of teaching. This will set the scene for the experiences of the student homeopaths and osteopaths, which will begin to be explored in the next chapter.

Historical perspectives

Neither osteopathy nor homeopathy are homogenous professions, either geographically or historically. Even within the UK, the unstandardized nature of the training institutions means that there is huge diversity in the experiences of graduating practitioners. A short history of the therapies and profession serves to contextualize

the experience of current students at the case study colleges, and serves as a backdrop for a discussion of the form and structure of the training courses.

Osteopathy

Osteopathy was founded in the nineteenth century in the United States by Andrew Taylor Still (1828-1917), a practising physician and ordained Methodist minister, as an alternative to the medical practices of the day. Still had become disillusioned with the methods of medicine practised by his profession at the time (including the application of leeches, bleeding, purging, and the use of toxic chemicals such as mercury and arsenic), and following the death of three of his children to meningitis, he set about searching for a new way to manage health (Coughlin, 2001). Still's research led to a detailed study of human anatomy, and he ultimately concluded that if the structure (especially the bones) of the body was not aligned correctly, or the function of the body was impeded, this could have far-reaching effects on many systems of the body, leading to disease. Nonetheless, this apparent focus on the physical body was never divorced from his strong religious beliefs and he believed osteopathy to be a philosophy.

The osteopath finds here the field in which he can dwell forever. His duties as a philosopher admonish him, that life and matter can be united, and that union cannot continue with any hindrance to the free and absolute motion (Still, cited in McKone, 2001: 28).

McKone (2001) argues that Still was influenced by Goethe and Hegel, specifically their ideas of organic form and interrelatedness.

Given the current moves within the British osteopathic profession to integrate with orthodox medicine, which have involved emphasizing the ‘scientific’ credentials of the therapy, it is important to note that osteopathy was founded on a unique set of principles, derived in part from Still’s philosophy and in part from his clinical observations. These principles have been re-envisaged a number of times in the history of osteopathy (McKone, 2001). However, today, there is no explicit mention of ‘osteopathic principles’ on the GOsC (General Osteopathic Council) website (www.osteopathy.org.uk). Nevertheless, while the official GOsC rhetoric seems to have written out the philosophical history of the profession, osteopathic principles are still considered vital to the practice by many, if not most, osteopaths. The major principles are (a) the interrelation of structure and function, (b) viewing the body as a unit or whole, (c) the body’s capacity for self-healing and regulation (that Still called ‘the medicine chest within’), which in its strictest form prohibited the use of drugs or medicines in any form, and (d) the importance of unimpeded arterial flow, and lymphatic drainage to and from the organs (‘the rule of the artery reigns supreme’). This latter observation was made before the discovery by medical science of the immune and endocrine systems and was at the time considered quite radical (Coughlin, 2001: 108).

The practice of osteopathy is often most strongly associated with treatments involving physical manipulation or ‘adjustment’, especially in the UK⁷. There are a number of ways in which osteopathy is distinct from biomedical and other modes of health care, which has profound implications for the teaching of the discipline as will

⁷ In the US, post-war, the struggle for parity of status of DOs – Doctor of Osteopathy - with MDs - Medicinæ Doctor (Doctor of Medicine) – resulted for some time in a de-emphasizing of the manipulation aspects of the practice (Coughlin, 2001: 108).

become clear in later chapters. Firstly, osteopathy has a holistic concept of disease aetiology,

The osteopathic concept of ill-health is primarily that of lowered resistance and stress of the individual rather than the domination and presence of micro-organisms. Past combinations of emotional and physical demands upon the individual will set the anatomico-physiological basis for the poor adjustment of the individual and the expression of ill-health (McKone, 2001: 231).

Another way of putting this is that the level of health is related to the *adaptability* of the body, and disease is a breakdown in communication in some aspect of the human form, be it emotional, physical, chemical or neural (Stone, 1999). This, in turn, has a significant impact on the purpose and process of case-history taking:

An integrative consciousness, in a time frame, should develop within the practitioner as the history is taken... the osteopathic case history [is] *a dialogue and narrative with the aim of understanding the interrelationships of health, ill health and injury as a reflection of the myofascioskeletoneuroendocrine-immune [meaning: various body] systems etc.* (McKone, 2001: 232, *emphasis in original*).

Secondly, the orthodox concept of diagnosis is often considered to be too 'reductionist' or 'disempowering' in osteopathy: 'While not wrong it weakens the osteopathic diagnostic and treatment potential if used without an osteopathic consciousness... [evaluation should lead to] the long-term development of an integrative and dynamic model' (McKone, 2001: 236). Nonetheless, the diagnosis 'somatic dysfunction' was coined when in the US the coding system (ICD) was developed for insurance reimbursement (Coughlin, 2001). An alternative term,

‘osteopathic lesion’ is also still common. Both diagnostic terms cover problems of asymmetry, restriction, tissue texture changes and tenderness (Coughlin, 2001).

Finally, the nature and depth of the physical examination differs from the orthodox model. According to McKone, the physical examination can, at least in theory, be divided into ‘quantitative’ and ‘qualitative’ aspects. Quantitative aspects focus on measurement of the range of movement of bones and tissues. Qualitative aspects include ‘observation’ and ‘palpation’ (gaining information about the body through touch). These selected passages provide an interesting summary of McKone’s interpretation of the embodied experience of palpating another person:

You are part of the phenomenon you are palpating. An impression is left after physical contact is broken;

Palpate with reflection and imagination not with total analytical visualisation;

Osteopathy teaches us to stand ‘behind’ the patient and, in Goethean style, palpate the patient *coming into being* as we are at that time in space

(McKone, 2001: 246, 247, 249).

It is clear that osteopathic practice makes for an interesting subject for an embodied sociology, because of the explicit focus on the bodies of both the practitioner and the patient.

Homeopathy

Homeopathy was also founded by a physician who became disillusioned with the orthodox medical practices of his time, and sought an alternative. Samuel

Hahnemann (1755-1843), a German physician and chemist founded homeopathy at

the end of the eighteenth century. He was an exceptional student but he was from a poor family and so to help finance his medical training (his fees were paid by an ‘anonymous benefactor’ generally presumed to be his school teacher) he undertook a great deal of translation work as he was fluent in at least five languages (Handley, 1990). The combination of his interest in the medicines used by his profession (he wrote what became a standard textbook, *The Pharmaceutical Lexicon*), and his concern about the toxic effects of many of these and what he considered the ‘barbaric’ practices of physicians at the time, resulted in him giving up practice, becoming a vocal critic of aspects of the profession and devoting his time to translation work and research (Handley, 1990).

Sparked by an interest in the use of cinchona bark (quinine) to cure malaria, he took the substance himself. He found that he produced all the symptoms of the malaria fever and that the symptoms disappeared when he stopped taking the bark, and it was from this experience that he began to develop the concept of ‘provings’ (Blackie, 1986). This was an experimental technique to ascertain ‘the characteristic action of medicines on human health’ by administering individual medicines in small doses to healthy people (‘provers’) (Hahnemann, 1986: 98). Hahnemann developed ‘The Law of Similars’, which states that a substance, which in a large material dose can produce symptoms similar to that of a certain disease, can in small doses cure that same disease. However, he found that even small material doses would often produce an ‘aggravation’ of the symptoms in his patients before they got better. Through years of experimentation, he discovered that by repeated dilution and ‘succussion’ (shaking vigorously between dilutions) of the remedy, the improvement could usually be started without an aggravation (Blackie, 1986). He called this process ‘potentization’ and advocated the ‘minimum dose’.

Hahnemann also fought against the dominant view of his contemporaries to claim the existence of a ‘vital force’:

The concept of the time was that in disease there was an evil in the body that had to be removed by drastic means. Hahnemann [by contrast] had come to the conclusion that in man there was a balancing mechanism which kept him in perfect health in spite of all the stresses of life, psychological, physical and atmospheric, provided that the stresses were not too great, or the balancing mechanism itself, which he called the ‘vital force’, was not impaired. But if the stress was too great or the vital force impaired, unusual signs, sensations and symptoms would follow. These were the *language of the sick body* (Blackie, 1986: 5, *my emphasis*).

For this reason, patients were encouraged to relate their symptoms, as much as possible, in their own words. The physician was to consider the *totality of symptoms*, and to be particularly attentive to those symptoms which are peculiar to the patient, rather than those that are common to the disease (Blackie, 1986). While Hahnemann rejected the concept of disease as ‘evil’, he remained deeply religious, much like Still, and his beliefs were vital to his understanding of health and disease.

Homeopathy grew in popularity during Hahnemann’s lifetime, and his second marriage to a young French marquise, Melanie, was instrumental in the consolidation of homeopathy in Europe. In particular, it was in Paris that he treated and taught Kent and Boericke, who produced some of the most influential homeopathic reference books. Melanie also learnt to treat patients with homeopathy, and set up a practice. She was taken to court twice, fined and both times returned to practice. On the third occasion, there was such an outcry from her patients that she was given a licence, and became, not only the first woman doctor in France, but also the first ‘lay’ homeopath as she was never trained in orthodox medicine (Handley, 1990).

Homeopathy came over to the UK in the early nineteenth century and, as explored in Chapter One, caused much controversy but managed to gain a significant foothold in the orthodox medical profession. In the 1960s and 70s, homeopathy outside of the medical profession, experienced a revival with charismatic leaders starting colleges and training ‘lay’ or ‘professional’ homeopaths. It is as graduates of these colleges, that many of today’s teachers and practitioners originate, and the legacy of this experience, including often the complete rejection of orthodox medical treatment, is evident in many professional homeopaths.

In many ways, the principles of homeopathy have remained unchanged since Hahnemann’s time, but new remedies are constantly being developed, sometimes in ways that cause much controversy. For instance, the use of meditation as a means to determine the action of homeopathic remedies, and the ‘discovery’ of new miasms, which are most simply defined as inherited tendencies or susceptibilities, are two areas which stimulate much debate within the profession today. What is probably most distinctive about different groups of homeopaths is the focus of their practice. Medical homeopaths are often accused by professional homeopaths of using homeopathy purely therapeutically to alleviate physical symptoms at the expense of a more holistic assessment. At the other end of the spectrum some homeopaths embrace the more esoteric and spiritual aspects of healing practice, including some of those who teach at the College of Homeopathy. Inevitably, these diverse ways of practising causes some tension within the profession.

In general, however, the focus of homeopathy is on the body in its widest sense, including physical, mental, emotional, social and often spiritual factors in the analysis of cases and the prescription of remedies. Homeopaths use two main types of reference books in their practice: the *Materia Medica* and the *Repertory*. *Materia*

Medicas contain information about the ‘provings’ of each individual remedy, arranged alphabetically, so that the homeopath can get an overall view of the pictures of each remedy. Often the authors will include a summary or ‘keynotes’ section at the beginning of each entry. As new remedies are added to the homeopathic pharmacy these books expand. In addition, sometimes the emphasis of how remedies are described changes in order to reflect changing culture, for example, changing views on homosexuality have forced changes in the descriptions of sexual practices. Repertories contain listings of symptoms and sensations (‘rubrics’) which are followed by remedies that are indicated for that rubric, in a graded fashion (usually grades 1-3 depending on frequency with which that symptoms were observed in ‘provers’). Usually the homeopath would consult a Repertory to look up the patient’s symptoms to get an idea of which remedies are indicated, then with two or three remedies in mind, s/he would consult the Materia Medica to take a decision on which remedy picture fitted the case most closely in a holistic way. For embodied sociology, homeopathy makes an appealing subject, because mind-body dualism is rejected in its philosophy, and ‘material’ doses of drugs or physical manipulation of the body is avoided in its treatment. Interventions are in the form of ‘potentized’ remedies, based on a holistic picture of dis-ease.

Osteopaths and homeopaths have experienced changes during their history, both in response to political and social pressures, and through an evolution of the practice through generations of practitioners. Chapter Five explores in more detail the practical philosophy of osteopathy and homeopathy through examining the processes by which the students of the college learn the ‘theory’ about health and healing. Here, it is important to note that osteopathy and homeopathy as taught and practised by

those at the two case study institutions is by no means representative of *all* osteopathy or *all* homeopathy. However, each practice has a unique way of interpreting the body and disease, which has vital implications for the ways in which students learn to *be* practitioners and provides a rich source of data for exploring the significance of embodiment in social knowledge and practice.

The College of Osteopathy

Founded in 1917, the anonymized ‘College of Osteopathy’ today runs a degree course which leads to a BOst qualification, recognised by the GOsC, that legally entitles the graduate to call him/herself an ‘osteopath’. There are two study options: full-time, which is a four-year course, or ‘mixed mode’, which involves part-time study for three years and then becomes full-time in the final two years. In 2004/5, when the research was conducted, there were over 350 students enrolled on the course.

The College of Osteopathy is one of the oldest and most well-respected training institutions in the UK and has been instrumental in the historical development of the profession in this country, including being a leading player in the change to statutory regulation of the profession. A significant part of this process has been the increased inclusion of medical science in the osteopathy curriculum, which has been used as a strategy to justify their legitimacy (cf. Welsh et al., 2004: 234). However, the College of Osteopathy has, at least in theory, also maintained its ideological commitment to seeing osteopathy as a holistic system of health care. The college defines osteopathy as:

a primary healthcare system, complementary to other medical practices. It is suitable for almost anyone and can contribute to alleviating an enormous range of conditions. The College

of Osteopathy regularly treats children, pregnant women, the elderly, shop, office and manual workers, professionals, dancers and sports people (college website⁸).

There is an ongoing debate in the profession between those who want to preserve the ‘classical’ foundations of the practice, and those who are keen to adopt more ‘scientific’ credentials, and many of these differing views are demonstrated by the staff.

The College of Osteopathy has its own teaching building on a busy high street in a large British city. The building is set over five floors; the ground floor has a large reception area, two large lecture rooms, a students’ union bar, and showers and lockers for the students. On the first floor is the Student Clinic reception and waiting area, the Clinical Vice-principal’s office, some teaching rooms for tutorials and specialist clinics, such as the ‘pregnant women’s clinic’ and the ‘children’s clinic’, a ‘staff room’ for the students and tutors to wait for patients and discuss cases, and about 20 small consulting rooms, each equipped with a plinth (treatment table), pillows, three chairs and, in the summer, a fan. The rooms are usually very warm, even in winter, because patients are undressing down to their underwear it is important that the ambient temperature is comfortable for them. Additionally there is a room with light boxes for looking at X-rays, and a couple of larger consultation rooms for tutors to conduct demonstration consultations in the specialist clinics (e.g. child, pregnant women, sports). The second floor has more consulting rooms, another staff room, the research department’s room, and another large lecture room. On the third floor is the library, the IT department, a student computer room, a number of staff offices, and two large teaching rooms, usually used for technique work so equipped with numerous plinths and pillows. The library is usually busy and it has

⁸ In order to preserve the anonymity of the colleges, website details are not given.

two rooms: the main one, with shelves of books and periodicals and desks for the students to work at, and a smaller second room that has anatomical models, skeleton specimens, big desks for group work and a video/DVD player for watching technique videos and videoed examinations from previous years. On the fourth floor are more teaching rooms, the Registry and other administration offices, the offices of the Principal and the two Academic Vice-Principals, as well as some other offices and a staff room for tutors. The building itself was built in the eighties with mid-height ceilings and box-like rooms. There has been some attempt to brighten the building up by painting the walls throughout magenta and putting up some paintings in the clinic, but the students often commented on how ‘awful’ the building was.

Nonetheless, the students make the most of the building, and inevitably spend a lot of time in the school, with full-time students typically having between 20 and 35 hours of contact time, including clinics, per week, and spending further time in the library and computer rooms. Students also make use of the cheap bar, with regular events and parties such as the ‘Hallowe’en Party’, and a small weights training room. Additionally some students use college rooms to run exercise classes for themselves in the evenings, such as kung fu and yoga. The students often develop strong social bonds with each other as they spend a lot of time together. The location of the college in a busy part of the city means that there are lots of local pubs and cafes nearby which the students use to socialize.

The College is often busy and bustling, with students, tutors and other employees, and clinic patients coming and going. The students’ union area, and the third and fourth floors are only accessible to students and staff with a key code. There is one lift kept free for staff and patients by prohibiting student use, which also serves to symbolically differentiate between the staff and students. The College of

Osteopathy employs a large staff, of approximately one hundred people, including the Faculty, administrative staff, and auxiliary staff, such as cleaners and receptionists. Members of staff perform distinct functions, such as administration, research, academic teaching, osteopathic technique or clinical supervision. Some members of staff may perform more than one function, such as being involved in both clinical teaching and research. Because of the size of the college, different departments operate independently to some extent, and my experiences in the college showed that they often had different perspectives and opinions about osteopathy in general, the training course and other issues, including my research. Almost all the staff members, except for the administrative and auxiliary staff, are qualified osteopaths with their own private practice, even if they teach subjects such as sociology or psychology. In addition, the majority of them are graduates of the College of Osteopathy. Usually, they had graduated, been in full-time private practice for a number of years and then returned to teach at the college. Most people assumed that because I was doing research at the college that I must be an osteopath too, so I often had to correct them. This is significant for the sense of community it generates at the college, but it also means that the college is a closed world to a large extent, with few alternative attitudes filtering in.

The College of Homeopathy

The College of Homeopathy was founded in 1993 by two experienced homeopaths and teachers who wanted to set up a new college based on their own experiences and beliefs about the practice of homeopathy:

Our aim is to create an environment that fosters the ongoing learning and growth of all our students and staff, in an atmosphere of mutual support and encouragement and with an absence of pressure to perform. Within this setting, we aim to provide the best possible training in homeopathy, flower essences and related holistic topics (college website).

There are two branches of the college in the UK, 'Northern' and 'City' colleges. The administrative offices are located at the 'Northern' college, but 'City' has more students, about a hundred, while 'Northern' college has about sixty. In both colleges students are divided into classes of no more than twenty. The course is part-time for three years; this involves students attending ten college weekends a year (Saturday and Sunday from 9.30am to 5.30pm), one two-hour tutorial a month, and, for second and third year students, a day of clinical training per month (about six hours). On graduation the students either receive a Diploma and Certificate of Attendance of the college or, if they have met all the assessment requirements as well as participation in classes, tutorials and clinics, they become a 'Member of the College of Homeopathy'. This enables them to register with one of the homeopathic registering bodies, thereby obtaining benefits such as insurance and enabling them to call themselves a 'Registered Homeopath'. Notably, the College of Homeopathy has not gone down the route, which a number of homeopathy colleges have, of developing partnerships with universities, and so retains its independence. Nonetheless, the principal of the college is very active in the CORH single register process and sits on CORH Council.

Research was conducted at 'City' college, which has no premises of its own instead hiring rooms in a large college located in a beautiful park in the same city as the College of Osteopathy. The college sets up a reception desk in the main lobby, where students sign in, and which at break and lunchtimes is transformed into the College Bookshop, and is a focus of activity and informal interaction throughout these

times. At each college weekend there are a number of tutors present, including the college principal and vice-principal, and each weekend one member of staff is assigned the job of ‘guardian’, which means s/he does not teach classes and so is available at any time for students to make contact with. The classrooms just about fit the twenty students in and usually the students arrange the desks around the edge of the room, rather than in rows, so that they can all see each other. Each class is assigned a room for the whole college weekend; it is the tutors who move in and out of teaching rooms over the weekend. Sometimes, especially in the summer, classes are taken outside in the college grounds, particularly ‘energy work’ classes, such as Chi Kung (see below). Tutorials and clinics take place at tutors’ private practices, sometimes located in their own home, and are organized by the tutors running them.

Because the course is part-time and the college does not have its own teaching building, students do not have access to communal areas such as a students’ union, although there is a canteen and a large courtyard garden in the college. In addition, the location of the college in a park means that students often spend time outside. Students do socialize between classes and over lunch, and obviously some students make close friends whom they socialize with between college weekends. However, most students only spend time with their colleagues during college weekends and at tutorials and clinics. This may be because many of the students have full-time employment or parenting commitments, and so their time is limited. To keep in contact with their classmates, there is a student message board on the college website, and often individual classes have email groups that they use to exchange information, such as relevant talks they have been to, ideas, websites, or to feedback their thoughts about the college weekends.

Because the College of Homeopathy hires rooms for teaching, there is no requirement to directly employ any auxiliary staff. There is an overlap between administration and teaching as only two full-time administrators are employed by the college (and they are trainee homeopaths), and so most tutors are expected to take on some administrative responsibility. All the teaching staff are practising homeopaths and they have a variety of specialisms, interests and experiences of using homeopathy. The atmosphere at the college is very family-like: the core tutors work closely together and know all the students personally. Once a year during the summer holidays, the ‘core’ tutors go on a staff development retreat to discuss plans for the following year. There are a number of regional tutors in addition to core teaching staff, who run the obligatory tutorials for students between college weekends. These tutors say that they do not feel part of the college to the same extent and are not involved directly in college level decision-making, but work on contract. They do not necessarily have much contact with other members of staff, but they invariably build strong relationships with the students whom they work with.

Re/producing knowledge: the training courses

This chapter now turns to the structure and content of the training courses and explores what sort of professional knowledge and skills are explicitly valued and promoted within the case study institutions. As Hirschorn points out, for CAM practitioners, ‘Knowledge claims, while not necessarily the determinants of professional status, represent a key vehicle through which these struggles are rhetorically played out, particularly with regard to science, both across professional groups and within them’ (Hirschorn, 2006: 534). In the field of health care, the

cultural dominance of biomedical knowledge means that it is hard to talk about health care knowledge without reproducing the binary dualisms of rationality/emotion, certainty/uncertainty, and even male/female, to some extent, but the picture is more complicated in reality. Indeed, within the settings, concepts such as objectivity, women's knowledge, and holism, which draw on these binaries, are sometimes deployed as rhetorical strategies, yet the principles of holism and a rejection of mind-body dualism are also frequently expressed.

To understand the positioning of the claims to knowledge that the colleges use, we can draw on Bourdieu's concept of symbolic violence, which is often exercised on those who promote alternative ways-of-knowing. As suggested in Chapter One, it may be possible for groups to resist symbolic violence, through authorization at a local level (Skeggs, 2004b: 25), which creates a distinct field with its own rules that revalue alternative ways of knowing and being. Alternatively, there may be some concessions to the dominant knowledge forms, and a re-interpretation of the practice in the light of these pressures. In both colleges, it is possible to see that the organization of the curriculum reflects the body of knowledge of the therapy, the stated aims and the values of the college and the political pressures facing the profession. These 'foundations' are important to understand for examining the experience of the students (in the next chapter).

Course content and structure

While both courses have consistent elements throughout the different years of training, it is possible to see patterns of emphasis in the course, which gives some insight into what, for educators, constitutes 'progression'. The structure of the

curriculum and the assessment schedule at the College of Osteopathy is heavily formalised, as the description below will show. By contrast, the curriculum at the College of Homeopathy is more flexible; while the general themes of the different years and the types of classes are consistent year to year, the content and emphasis is subject to feedback from the students and timetables are prepared month to month. In both colleges, the terminology used to describe the elements of the curriculum may be mystifying to an outsider. During the course, the students' growing familiarity with this (sometimes medical or esoteric) language illustrates that 'progression' involves the normalizing of a certain outlook and framework for understanding the body in health and illness.

The osteopathic (BOst) course consists of six compulsory 'units' (which unlike optional 'modules' are considered by the faculty to be fundamentally interdependent). Each unit has clearly defined and published 'learning outcomes' which are available to the students at the beginning of each year. The five units are (1) Structure Function (SF), which is anatomy and physiology from the point of view of how it contributes to bodily 'function'; (2) Function Dysfunction (FD), which is the study of pathology, and takes as its premise that there is a spectrum of states from health to pathology and conceives of 'illness as adaptation'; (3) Practical Osteopathic Skills (POS), which includes 'interactive anatomy', and all 'technique' classes (clinical examination skills such as observation, palpation, and treatment techniques); (4) Conceptual Basis of Osteopathy (CBO), which includes the principles of osteopathy, the history of osteopathy and medicine, in part to establish what is distinctive about osteopaths, and classes in sociology and psychology; and (5) Professional Capability (PC), mainly consisting of work in the student clinic, but also including classes in communication skills, ethics, case-history taking, and patient-

practitioner relations. Finally, (6) each student must complete an Individual Inquiry (IE), or research project, to be submitted in their final year (for a full breakdown of the course structure and assessment, see Appendix 2).

Overall there is a fairly even split between ‘academic’ and ‘practical’ work. Academic work includes scientific learning of anatomy and pathology, and developing skills in critical debate and discussion. Practical work includes the development of embodied skills, clinical experience and reflective practice. However, the emphasis given to each of these units changes throughout the course. There is a clear trend which forefronts the academic learning, and as the course continues the students spend a greater proportion of their time gaining clinical experience and developing their practical osteopathic skills. Longitudinally, the four years of the course are termed the ‘Orientation phase’, the ‘Consolidation phase’, the ‘Integration and Synthesis phase’ and the ‘Pre-professional phase’. Students are required to get a ‘grounding’ in SF, FD and analytical skills such as critical reading, sociology and psychology before they are allowed contact with patients. The Orientation phase is assessed almost entirely by written course work and examinations (SF, FD, CBO, PC) apart from a practical (non-written) exam in ‘osteopathic technique’ for POS.

In the Consolidation phase, the SF and FD aspects of the course (the most purely academic aspects) become more specialized, including courses such as ‘child development’. POS remains an important component throughout the course and in this phase, the ‘technique’ classes begin to focus more on treatment techniques rather than just learning how to palpate and recognize certain bones and tissues, and the students learn ‘applied technique’ and start an IMS (Involuntary Motion Studies) course, which gives them the opportunity to learn some cranial osteopathic techniques

which are much more gentle. CBO involves lectures and tutorials, and students are assessed on 'critical reading', sociology, psychology and also do a short answer question paper on topics covered during the year. PC becomes more practically focused, with a course in 'diagnostic and clinical procedures', 'osteopathic evaluation and diagnosis', 'communication skills' and the students begin to observe the more senior students in clinic.

Beginning after the Consolidation phase, students share out clinic responsibilities over the summer holidays, and each student spends four weeks in the student clinic. For the students finishing the Consolidation phase, assuming they have passed all their technique exams, they get their first opportunity to take responsibility for their own patients (with supervision). Students are required to keep records, discuss cases, and attend group tutorials during clinic hours to develop areas of practice in a informal environment. Students are subject to ongoing assessment in this environment and receive clinic tutor reports (PC) each year.

The Integration and Synthesis phase brings more detailed and specialist knowledge into the SF and FD components. The technique classes for POS includes learning HVT (high-velocity thrust) techniques, and specialist treatment such as 'rehabilitation technique'. The focus of the CBO unit (carrying less credits than previous years) is on students developing their own clinical style as well as exploring case analysis in more detail. PC includes two half days per week working in the clinic. At the end of this year, the students must submit a research proposal for their Individual Enquiry. This year marks the end of the conventional academic exams, and are often referred to as 'finals' by the students, and further illustrates the move from academic to practical skills.

During the Pre-professional stage, there is a significant overlap between the CBO and PC components. Mostly this year is devoted to, as one senior tutor put it, ‘the development of practical knowledge’ and classes on business and professional aspects of practice. Technique tutorials continue, with students having much more influence on what they want to focus on in these sessions. Clinic work in this final year takes up four half days a week, and work continues on ‘clinical competency’, assessed both by a report by tutors and through the students’ own development of a ‘portfolio report’. Students also prepare a case presentation (the ‘concepts case’, as the students refer to it) that draws on what they have learnt in CBO, so should demonstrate their understanding of osteopathic concepts and the role of social and psychological components in the treatment of disease. In addition, students work on their Individual Enquiry, which is an independent research project that must be submitted in the form and style of a chosen osteopathic journal, and which they are required to give an oral presentation on to examiners.

The course at the College of Homeopathy is much shorter than the one at the College of Osteopathy. Students are expected to do a significant amount of independent study between college weekends and to explore their own particular interests in detail during that time. The college weekends are themed according to the year of study by content (rather than ‘stage in the course’ as at the College of Osteopathy). The first year of the course is structured by *body systems and organs*: Skin, Skeletal System, Digestive System, Liver and Gall Bladder, Kidneys, Lungs, Heart, Nervous System, Brain, and Endocrine System. In addition, students cover the key ‘polycrest’ remedies, such as Sulphur, Pulsatilla, China, and Phosphorus, which are the remedies most widely used in practice. The second year is structured by *life course*: Conception and Fertility, Pregnancy and Birth, Breastfeeding and Early

Childhood, Childhood, Adolescence, Male, Female, Menopause, Old Age, Death and Dying. In addition, this year the students cover the homeopathic ‘miasms’. The Greek *miasma* literally means ‘pollution’, and a simple definition of miasms in homeopathy is a theory of inherited or acquired disease patterns and susceptibilities, usually caused by the suppression of illness through toxic drug applications. The students study the Psoric, Sycotic, Syphilitic, Tubercular, and Cancer Miasms. The final year is structured by *chakras* (term derived from the Sanskrit word for ‘wheel’, and indicating physical/spiritual energy centres in the body): Base chakra, Sacral chakra, Solar Plexus chakra, Heart chakra, Thymus chakra, Throat chakra, Brow chakra, Crown chakra. The final year also covers in detail some of the big issues that practitioners are confronted with in practice, such as Cancer, Eating Disorders, ME, Addiction, HIV and AIDS, Toxicity and Organ Drainage and Nutrition. The final weekend is themed ‘Completion’ and includes a graduation ceremony, where each graduand is individually acknowledged through a short speech by a member of the teaching team.

Each weekend contains a balance between different types of classes. These include Homeopathic Principles and Methodologies, which looks at the major concepts and theories in homeopathy, such as susceptibility, vitalism, the law of cure, and suppression, as well as different methodologies for treatment and different models of practice; Materia Medica, which covers the main constitutional homeopathic remedies as well as a large range of clinical and therapeutic remedies; Personal Practitioner Skills, which includes a wide range of aspects of clinical practice such as anger, energy, body language and voice, grief and separation, and boundaries; Repertory Skills, which explores the language of the repertory and using it as a resource to find appropriate remedies; Case Taking, both of acute and chronic

conditions; plus classes on flower essences, nutrition, and ‘energy work’, such as shamanic work and Chi Kung. Finally, there are ‘Learning Journal’ sessions, which provide an opportunity to both explore, support and monitor the progress that students are making. The balance of these types of classes is relatively even throughout the three years of the course.

Although the biomedical model is not considered directly relevant to the philosophy or practice of homeopathy, students are encouraged to be familiar with biomedical terms on the basis that it is useful to have a common language to work with patients and other professionals. To some extent the more ‘physical’ components of the course are forefronted, with the first year themed by ‘body systems and organs’ and the more overtly spiritual concept of ‘chakras’ being tackled in the final year. However, the ‘body systems’ lectures are discussed from, what the tutors term, an ‘energetic’ perspective meaning that physical body systems and organs are not separated from the associated mental and emotional connections. Learning biomedical anatomy is encouraged in the student’s own time, but is not taught in lectures, or directly assessed. Similarly, the ‘chakras’ are explored as concepts that cut across the conventional Western distinctions between mind, body, emotions, environment and time, and often provide a springboard for detailed discussion about associated physical pathology as well as spiritual distress. Each chakra has affinities with various organs in the body, and stages of life, thereby linking into the previous years’ themes.

There is a huge emphasis on the personal development of the student homeopath, in terms both of professional skills and personal health and well-being. The College values the balance between ‘inner’ and ‘outer’ learning, learning through experience, reflection and self-responsibility (see Appendix 3 for a full statement of

the aims of the College), and these are reflected through the modes of assessment, discussed below.

Teaching styles

The types of classes and teaching styles differ at the two colleges. The students' embodied experiences of and responses to these classes will be explored in the next chapter. Here, I provide a sketch outlining the teaching format and the aims and beliefs of the teaching staff, drawing on Belenky et al.'s distinctions between teaching styles:

Midwife-teachers are the opposite of banker-teachers. While the bankers deposit knowledge in the learners' head, the midwives draw it out. They assist the students in giving birth to their own ideas, in making their own tacit knowledge explicit and elaborating it (1997: 217).

At both colleges, the teaching staff aim both to promote the individuality of the practitioner, while also ensuring that students get a good grounding in the practice.

The College of Osteopathy states that students are encouraged, alongside a number of learning objectives, to 'develop their individual style' (college prospectus). The College of Homeopathy states that, 'Our tutors have a wide range of expertise and our curriculum is broad and flexible, allowing our students to learn the essentials whilst also remaining free to develop their own interests and skills.'

Achieving this balance between structure and flexibility potentially creates a degree of tension in the curriculum. If students are to learn the 'basics' then a banker-teacher approach is perhaps most viable and efficient, but the lack of creativity in this kind of teaching environment could stifle the student's ability to think independently.

A midwife-teacher would encourage the students to develop their own skills, placing less emphasis on the acquisition of facts, but it may be difficult to ascertain whether the student had achieved an acceptable standard of practice. Teaching styles also have implications, to be discussed in the next chapter, about how students negotiate the course.

At the College of Osteopathy, there is evidence of both styles of teaching. On the one end of the scale many of the SF and FD lectures are very orthodox in style, with one lecturer imparting information to a large group of silent, note-taking students, often with the assistance of technical props, such as projectors or overheads, and sometimes models of skeletons, or parts of skeletons. Other lectures are more informal and interactive in style, with fewer students per class, involving discussion and contributions from the students. Some, such as ‘Diagnostic and Clinical Procedures’ (POS), involve the demonstration of basic medical techniques (such as reflex testing, or taking blood pressure) which are then practised by the students in class. Lectures are often followed up, however, by tutorials which are much more interactive. There are also stand-alone tutorials for subjects such as Critical Thinking, and Interactive Anatomy. Tutorials often involve small group work, partner work or class discussions.

However, in osteopathy the development of embodied skills (the characteristic ‘manipulation’ aspect of the practice) cannot be taught in a conventional lecture format. The students have to get ‘hands-on’ learning experience. Probably the most distinctive type of classes at the osteopathy college are the ‘Technique’ (POS) classes. These are conducted in large rooms with numerous plinths and usually last for two hours and forty minutes. There are usually three to six tutors (per twenty students) who demonstrate techniques and then circulate in the class assisting students. The

students work in pairs, and swap partners throughout the classes to get to practise on a variety of different people. The classes are often very quiet with students practising their palpation and treatment techniques on each other and occasionally talking and feeding back to one another. There is a huge amount of physical intimacy generated in these classes, as students must touch each other's bodies throughout the classes. (The ways in which the students' own bodies are implicated in the training process is revisited throughout the thesis.)

At the College of Homeopathy, students remain in the same class groupings, of no more than twenty, throughout the three years of the course. Students are never taught in bigger groups. Part of the reason for this is the emphasis that the course places on the personal development of the students, in terms of their own health and their skills as a practitioner. Indeed, the development of practical and reflective skills is at least equal in importance to the teaching of 'facts'; the College states that 'We believe that healing is as much about the relationship between a practitioner and patient as it is about any remedies we might prescribe. We spend considerable time developing interpersonal skills and other useful practitioner skills' (college website). While the students do not have to undress to practise therapeutic techniques, as the student osteopaths do, there is still a great deal of intimacy generated in the class at an emotional level. The students discuss diverse issues such as grief, anger, childhood, abortion and relationships, which bring up many emotional responses which the tutors encourage the students to explore and process, in order that they might become more aware of their own ways-of-being and sensitivities and be able to be reflexive about them. (These aims of 'reflection' and 'self-awareness' will be returned to and explored in different embodied contexts throughout the thesis.)

The homeopathy college encourages tutors to use a variety of teaching methods, which include conventional lecturing, interactive learning, guided meditations, and what is termed 'energy work', which includes teaching practices such as Chi Kung. Generally, the atmosphere is informal, with students free to ask questions and offer opinions at any time. The vice-principal, who is responsible for the timetable, explained to me that he tries to give each year group a balance of different types of classes each day, so that there is not 'too much listening' in one go. Tutors draw on their own individual skills and personal experiences to enhance and diversify the learning process. For instance, one tutor is also a shamanic practitioner, and will sometimes partly teach remedies by taking students on a shamanic journey (using a drum) with the remedy. One of the reviews of the homeopathic miasms is done by a tutor who is also a professional concert pianist and he plays pieces of music that reflect his interpretation of the miasms to the students. Another also practises Chinese Medicine and will makes links to that framework in her teaching.

Some of the tutors took pains to explain that their interpretations were only their models or their politics, as opposed to being 'the truth' about homeopathy or homeopathic practice. On the other hand, a couple of the tutors did take a more 'banker-teacher' approach. Although the following two examples were of male teachers, and Belenky et al. (1997) associate this model of teaching with masculinity, my sample was too small to make any generalizations. One tutor was prone to using numerous technical medical terms when describing anatomical functions or diseases, which the students often seemed baffled by, or would ask him to write the terms on the board. This symbolically reinforced the distance between himself and the students in terms of the amount of knowledge they possessed. Another tutor, who often

lectured on philosophy, would often say things such as ‘this is what homeopathy is’ in a manner that precluded debate.

However, a large proportion of the teaching at the College of Homeopathy resembles the midwife-teacher model, because of the value placed on the student’s own exploration and experience of the subject. Belenky et al. talk about ‘inner-outer’ sources of validation (1997: 204), and the emphasis on self-assessment certainly seems to reflect a validation of ‘inner’ knowledge. The college states, ‘We believe that the process of becoming a good healer is as much about an inner journey as it is about learning information and skills. So as well as teaching the necessary content we place emphasis on personal experience, building confidence and developing self-awareness.’ This deployment of the inner-outer binary serves to locate the knowledge production of the College of Homeopathy in contrast to courses that focus on academic teaching (both inside and outside of the profession).

While, in general, there is a balance between different ways of knowing, sometimes value is placed on the ‘body’ or ‘female’ side of the dualism. A belief affirmed by many of the tutors (although not all, notably some of the men) at the college is the idea that students are being taught in order that they might ‘remember their connection to earth, body and spirit’. There is clearly a political undercurrent to this aim which is that ‘modern’ life and (sometimes implicitly and sometimes explicitly) ‘patriarchy’ have meant that we ‘as women’ or ‘as humans’ have lost our connection to the earth. This bears similarities to ideas of feminist spirituality or ecofeminism. King describes the latter as a political viewpoint ‘where we will fuse a new way of being human on this planet with a sense of the sacred, informed by all ways of knowing, intuitive *and* scientific, mystical *and* rational’ (King, 1989: 134). This potentially creates tensions for the small number of men on the course or for any

students who have been brought up in an environment that values stereotypically ‘masculine’ ways-of-knowing about the world and the body. However, the expression of these values is usually couched in terms of ‘re-balancing’ in an unbalanced world, rather than rejecting scientific and rational ways of knowing altogether.

Assessment

At both colleges, expertise is generally recognized as something that can only be worked towards once training is completed and the students are practising professionally. However, students must demonstrate that they have achieved a certain level of safety and competence in order to graduate. It is interesting to ask what sort of knowledge or skills must be demonstrated in order for the student to prove that s/he is worthy to be registered as a qualified practitioner. Student responses to these modes of assessment will be explored in the next chapter.

The osteopathy students are very heavily assessed at all stages of their training, not least to satisfy the stringent requirements of the GOsC (see Appendix 4). Assessment involves a combination of conventional and practical examinations, written coursework, portfolios and ongoing assessment in clinics. In the final year students also have a Final Clinical Competency (FCC) examination, where they are observed giving complete treatments to three patients (one existing and two new patients). The practical examinations are organised as a series of ‘stations’, where students must complete a task in the presence of an examining tutor which may be of an oral theoretical or practical technique nature (a senior tutor explained that these exams had been adapted from the traditional medical version to include practical as

well as theoretical assessment stations). For instance, the students may be asked to palpate or evaluate a part of the body (on a student volunteer), to take a case history, or explain the possible treatment options for a certain complaint and demonstrate these. This mode of examination and the FCC can be seen as a validation of the embodied practice of osteopathy, in contrast to the theoretical testing in the written examinations. Nonetheless, there is a huge emphasis on reproducible abstract knowledge. Graduating is dependent on a student's ability to demonstrate competency and 'safety' in practice.

By contrast, there are no examinations at the College of Homeopathy; students are required to keep a 'learning journal'. The college states, 'We believe that learning can be a pleasurable and empowering experience without placing an unnecessary academic burden on our students. We do not set exams on our courses, but instead we encourage students to develop in their own style and at their own pace by means of personalized learning journals and self-assessment.' This avoids what Belenky et al. call the 'doubting or adversarial model': 'Because so many women are already consumed with self-doubt, doubts imposed from outside seem at best redundant and at worst destructive, confirming the women's own sense of themselves as inadequate knowers' (1997: 228). The learning journal resembles in many ways the kind of 'portfolio' learning that has developed increasing kudos in many educational settings. Students are expected to construct a record of their learning experience during their time in college, including work they have done in addition to the college weekend. This record includes much of the 'academic' work, but is also supposed to be a record of their personal and professional development as well. The journal can be presented in any format that the student chooses. It may, for example, consist of filed lecture notes and additional readings and a reflective diary. For other students these aspects

may merge into one document. For others, they may also paint, or compose music that reflects and expresses their own learning experiences. In order to pass the course, the students must also attend at least eighty per cent of all the college weekends and tutorials and are assessed by tutors on their performance. They must amass 150 hours of clinical training, and be recommended for practice by the clinical supervisors. In addition, they must submit five written cases that they have taken and prescribed for during their training. This final requirement is the most traditionally academic aspect of the course assessment, and demonstrates the student's ability to analyse cases in a homeopathic way (see Chapter Six). The overall aim of this training is to produce students who are confident in their own abilities to be a successful and effective homeopath, and to set the groundwork, in the form of the learning journal, for a continuing process of learning and self-development.

At the College of Osteopathy the standards and goals, the pace and the evaluation of the outcomes of learning are dictated to the students. If students fail any of their assessments they are required to re-take over the summer or to repeat the year. By contrast, at the College of Homeopathy, to a large extent the students set their own pace, determine their own mode of recording their learning and identify their own personal goals. Exceptions to this are the requirement to write up cases, and the minimum attendance requirements. If the students are unable to submit all their cases, or clock up their clinic hours by the end of the three years of training, they do not fail but are given a 'certificate of completion' and granted time to complete the other components to achieve the full qualification as a 'member' of the College of Homeopathy. Both colleges require ongoing clinic assessment, and students must receive favourable reports from their clinical supervisors in order to graduate.

Conclusion

This chapter has provided a ‘sketch’ of the research field that focuses on the historical and political influences on practice and training in the profession, and on the current structure of the course that is in place before the students arrive. In their origins, the therapies were ‘alternatives’ to orthodox medical practice, but over time that has changed with varying concessions to biomedical knowledge and integrated practice. Nevertheless, it seems clear that in osteopathy and homeopathy, certain knowledge and skills are emphasized and valued in unique and distinctive ways (in comparison to each other and, implicitly, orthodox medicine). The chapter has introduced the course content and structure, teaching styles and assessment requirements, and begun to discuss them in terms of how different ways of knowing are valued by the professional educators. The course curricula and the tutors provide a certain degree of pre-determined structure and organization for incoming students. However, the organization of each course also incorporates varying degrees of flexibility in the student experience. This chapter, therefore, sets the scene for the discussion in the following chapter about how students negotiate the course.

FOUR

Negotiating the course: student responses to the curriculum

Introduction

Students are not passive actors in the educational environment. While the structure of the course and the attitudes and teaching styles of the staff are inevitably somewhat fixed, this chapter explores the ways in which students are able to ‘negotiate’ the course rather than being passively socialized into the profession. As students are self-selected into the profession, it may be that their capabilities and preferences for certain ways of knowing are already embedded to a certain extent. This chapter, therefore, turns first to an introduction to the characteristics of the osteopathy and homeopathy students, and their routes onto their respective courses. During their college experience, the students have some of their pre-existing beliefs and perceptions reinforced, while in other areas they may experience tensions. This chapter shows the ways in which students respond actively (a) to the course over the years they attend, in terms of the staging of learning (b) to the emphasis given to different ways of teaching/learning about the body and healing, and (c) to the modes of assessment at their college. Special attention is paid to the ways in which the body of the practitioner is deeply implicated in practice and training for practice, and the ways in which students manage and reflect upon their own experiences.

Introducing the students

The Osteopathy Students

In 2004/5, there were over 350 students enrolled in total on the BOst degree course at the College of Osteopathy. About 70% of students go through the full-time course and 30% through mixed mode. There is a drop-out rate of approximately 10% in the first year for full-time students, and 20% for mixed mode. After the first year, the drop-out rate is less than 1%. There is a relatively even gender distribution on the course, with only slightly more women (see Appendix 5). While a large number of students come to the training immediately post A-level (17-20 years), over seventy percent of students are older than that, with numbers tailing off above 35 years, but with a few students in their fifties. I was not able to get figures on ethnic background of the students, but, from my observations, the students come from a diverse range of ethnic backgrounds. Nonetheless, the largest ethnic group was white, and this comprised a number of, mostly European or Australasian, nationalities.

In the year the research was conducted there were approximately three applications per place for the course. Most students apply through the UCAS standard pathway, with a requirement of BBC at A-level or equivalent (B in Biology, and B in another science subject, preferably Chemistry, C in anything). Mature applicants without qualifications above GCSE/ O-level, or who hold non-science A-levels but have been out of education for some time, need to do an Access course first (for which there are approximately 4 applications per place). Fees were about £3000 a

year⁹, and because the intensity of the course leaves little time for alternative employment and living costs are high in the city, it was a serious financial undertaking. The cost of the course puts many students hugely into debt, but the College of Osteopathy prides itself on the fact that ‘93 per cent of College of Osteopathy graduates are employed as osteopaths within six months of graduation’ (college website). A number of students commute quite a distance to come to the college, some even do the Mixed Mode course from other European countries for the first three years. Other students are living with their parents or relatives, even the ones in their twenties or thirties in order to be able to afford to do the course. Many students found that the cost of the course was very difficult to manage, especially mixed mode students who have balance part-time work and study.

The educational and professional background of the students is varied, and it was not possible to get exact figures on previous employment. However, an approximate picture was gained from talking to students and to the admissions secretary. Approximately 30% of the intake are students coming directly to the College of Osteopathy after A-levels. Of the remaining 70%, about a third were undertaking a complete career change, from areas such as finance and banking. They had usually had an ongoing interest in health or exercise (e.g. yoga or massage). The second largest group is the (growing number of) recent graduates, who usually have degrees in subjects such as biological science, veterinary medicine or zoology. Another large group of students have had a main career in another area of health or fitness – such as sports coaching, pilates, or sports massage. These students tend to have vocational qualifications and the admissions secretary pointed out that some

⁹ The year the research was conducted was the final year before the College of Osteopathy developed a partnership agreement with a university; hence the college has now become eligible for government funding and those students for whom this is their first degree can get student loans. This unsurprisingly resulted in a growth in the number of applications the following year.

prospective students from this group are put off because of the need for academic qualifications for admission. A smaller proportion of new students include mothers coming back into full-time education, people who have been working abroad as holiday reps, or teaching English as a foreign language, and overseas students, usually from the EU (especially France and Spain).

A year group consists of sixty students, each of whom are assigned to one of six 'groups'. This provides flexibility in class sizes, with some lectures delivered to the whole year (all six groups), or to a half year (three groups), and with other classes, such as technique or tutorials that require more interactive teaching, taking place with only one or two groups present. For clinical training, students are organised in different groups that comprise a balance of different year groups. This means that students have the opportunity to develop collegial relationships with a large number of others.

In general, the osteopathy students dress casually for classes. They resemble 'typical students' to a large degree: jeans, T-shirts, trainers etc. and seem to see themselves as such, at least in the first couple of years. However, their clothes have to be practical, and appropriate. The students must wear comfortable clothing, and often have to get undressed down to their underwear during 'Technique' classes. Students, therefore, wear underwear that is modest, and I was warned that I should 'wear big pants' if I was participating in a technique class. Some of the women bring a change of underwear for Technique classes, or a little pair of shorts to put over their knickers. Very quickly during the course the students appear extremely comfortable with taking their clothes off in class, and certainly they report an ease with it. However, the casual-wear and 'student' look has to be modified when the students are working in clinic. They are expected to wear smart shoes and skirt or trousers, and a

white coat. The expectation is that they appear 'professional' in terms of both clothing and personal appearance. Women with long hair often tie it up, and one of the male students commented, 'I really should get my hair cut because I'm going into clinic next week'.

One of the most notable things about the osteopathy students was their physical ease with others, perhaps as a result of their constant attention to the body and the physical intimacy of their practice. They are generally confident and extremely tactile, especially compared to the majority of the UK population who are notoriously reserved and physically undemonstrative.

The Homeopathy Students

There is a much more significant gender bias in the homeopathy students, approximately ninety percent are women, and only ten percent are men. I was not able to get exact information from the college about student ages, because they do not keep it on their computer system, but from my observations there seems to be relatively even spread between twenty-five and sixty years old, with a cluster around late thirties. There are no post A-level students and only a couple of recent graduates. The course costs approximately £2250 per year, plus about £35 per month for clinics in the second and third year. As the course is part-time, most students continue their full-time jobs during the course, including teaching, business, IT, music, fashion, and academia, while others are full-time mothers, or retired. A number of students practise or are trained in other CAM therapies such as reflexology, Reiki or massage.

The students come from a variety of socio-economic and educational backgrounds, although most are within the middle-class spectrum. From my

observations, approximately twenty percent of students come from minority ethnic groups, about fifteen percent of students come from non-British EU and Eastern European countries, and about ten percent from non-European countries. The application process involves the submission of an application form and a telephone 'chat' (as opposed to interview). The college values life experience over official qualifications, and students are not expected to have any particular qualifications, only a demonstrated interest in homeopathy and a understanding of the required commitment to the course. In this way, places on the course are largely allocated on a first-come-first-served basis. Drop-out rates are low, at under 5%. Although the college does not collect information on graduate employment, it is certainly not the case that most graduates start practising full-time immediately on completion of the course. Many will continue their previous jobs and practise part-time, or gradually phase-out their previous jobs as they become busier.

Each class consists of no more than twenty students, who remain as a teaching group throughout the three years of the course. Tutorials have up to six students in each group who can be from any year group. Similarly, clinics have up to six students and consist of a mix of second and third year students. Compared to the osteopathy students, the homeopathy students probably work with a smaller number of different tutors and other students over the course. Instead, the focus is on building supportive relationships that encourage the development of trust and openness, facilitating the more emotionally intimate environment at the college. One student commented at the end of her first year, 'I've spent a year with you all and I feel that I know you so well, yet I don't even know what some of you do for a living. We have a different kind of connection, not all that superficial stuff you get at work dos and dinner parties'.

Compared to the osteopathy students, the student homeopaths look less like ‘typical’ students, as they have an eclectic style of dress, some very colourful or bohemian, others stylish, fashionable or practical. This may be partly to do with the older age of most of the student homeopaths, but may also be a reflection of the extent to which individuality in all areas is valued at the college. Unlike the College of Osteopathy, the College of Homeopathy makes no statements on student dress, in clinic or otherwise, and none of the tutors or students wear white coats. At no point during the research did I hear any suggestion or discussion that homeopaths should wear white coats. Although this absence is not representative of the whole homeopathic profession, at the College of Homeopathy I suspect that it would be considered strange, maybe even worrying, if a student expressed a desire to wear one (see Chapter Six for a discussion of white coats).

Student responses to the osteopathy curriculum

The different backgrounds of the osteopathy students mean that they experience aspects of the course in different ways, and tackle different components with varying ease. The students’ negotiation of the course and their responses to the heavy load of assessment gives insights into the their construction of the meanings of the course and its implications for their future practice. They do not unquestioningly accept the organisation of the curriculum, the staging of learning, the nature of assessment or the opinions of the tutors. Nevertheless, their financial and social investment in graduating from the college means that they must, at least on the surface, learn and demonstrate the skills and knowledge required by the course.

Course content and structure

First, I will examine the student osteopaths' responses to the staging of learning from abstract and generalized knowledge to embodied knowledge that can be adapted to individual cases. It is clear that different aspects of the course generate diverse responses from the students depending, in part, on their own past educational experiences. One of the College's aims is that the students should develop an 'individual style' which generates feelings of uncertainty in the students, which they must actively manage. The bodies of the students both shape their experiences and are shaped by the experience of learning.

The early focus, during the first year, on academic knowledge of the body in the SF and FD units, and the academic work in CBO, is problematic for some students who have reported feelings of 'disillusionment' or 'frustration' at this stage. Often training as an osteopath is a career change, and the weight of the academic focus is not what they expected when enrolling on a course to train in a profession that is largely associated with physical manipulation. Additionally, the variety of educational backgrounds of the students meant that while some found the academic work 'repetitive and boring', others felt 'swamped'. Much of the academic content of the course is taught in conventional lecture format, producing clear distance between 'knowledgeable' tutors and 'novice' students. Through the use of symbolic markers, such as a stage, and the ability of the tutor to demonstrate command of the material, this distance is reinforced. Nonetheless, the students do express admiration for some of their teachers because of the apparent breadth and depth of their knowledge. Here the value is assigned to 'mastery' of knowledge, but it is unclear as to whether the

students aspire to this as well, as other observations suggest different priorities and interpretations of progress.

During the second year, students welcome work on the more practical applications of their knowledge. A student comments, 'I know what it was that I liked about that class – *integration* – we were actually starting to see how all the parts of the course might fit together for a single patient'. The basic anatomy from the previous year is beginning to be learnt in a more practically focused way. A lecturer says, 'We want to redefine first year anatomy to be relevant in a clinical context' so 'think about these structures as not being born with the anatomy in Gray's and dying with it but as a growing process'. However, for the students this generates feelings of impatience, uncertainty and awareness of how much they do not yet know. Tutors try to keep control of the process, 'Just be aware at this stage and then when you observe things in clinic, come back next year and we'll do this again'; and responding to a question from a student, a lecturer says 'I'm not going to answer that now as we are getting into third year mode there'. Nonetheless, the students place great value on work that has clear clinical applicability. After a second year DCP class (Diagnostic and Clinical Procedures), one of the students commented that although they practise techniques such as reflex testing in the class, 'it is only when you see the third and fourth years using these techniques in the clinic that it means something, that you can see the significance of it'.

The time spent in clinic at the end of their second year, when the students first have responsibility for treating patients is, according to one tutor, 'pretty tough for the students, after all they haven't even learnt differential diagnosis yet!' However, the learning by doing is exciting for the students, and they appreciate the experience of making progress. One student explained that he had found it really nerve-wracking to

start working at the clinic, but ‘even after a week, I feel so much better at taking cases’. The different educational and professional backgrounds of the students have an effect on their experiences in clinic as well. Tutors particularly often commented that while post A-level student and graduates found the academic parts of the course easier to manage, those with experience working in other healthcare professions or with teaching bodily skills (examples are pilates, kung fu, yoga, rolfing) often found the patient-practitioner aspects of the course much easier to excel in. A tutor commented, ‘The young ones [post A-level] often have no clue about how to make someone comfortable in a consultation.’

For the students, being successful in their clinical practice was the critical measure of success, and often superseded academic knowledge. In clinic, a fourth year student commented, ‘Suddenly I realized how far I had come when you can feel things [in the patient’s body] and the second years who come in to observe us can’t.’ A couple of fourth years were discussing the fact that first year students often use the (low-cost) student clinic for treatments, and were joking about how the first years often ask questions about the names of specific bones or muscles: ‘They assume we will know everything!’ However, they said that by this stage they have forgotten some of those details. What was interesting was that this was presented by the students as a positive development, meaning that they were practising real osteopathy now. This can be interpreted as students valuing an interactive and embodied appreciation of the human body over abstract details of anatomy. This can be linked to the curriculum ‘progression’ from knowledge (including embodied knowledge) about and familiarity with tissues in a general sense, to it being relevant to actually helping specific patients with their problems.

Progression to an 'individual style' in the osteopathy course is carefully staged, which can generate feelings of uncertainty that the students must negotiate with tutors. For instance, in 'Technique' (POS) classes students learn palpatory skills and osteopathic techniques for treating patients, which is often valued as the practical knowledge central to osteopathy. (The content and embodied experience of participating in these classes will be explored further in Chapter Five.) Each student must produce this embodied palpatory knowledge 'from scratch' becoming slowly more familiar with the feel of their own and other's bodies in relation to one another. As one tutor explained, 'There are no certainties here... we can only try to get you to feel what we feel. We can't feel it for you'.

Students are encouraged to gradually appreciate that there is no single right way of doing things; effective practice is dependent on individual characteristics. For instance, Orientation phase students must take an exam in technique and they are taught very specifically where they should place their feet and what stance to adopt for each technique. This is ostensibly to ensure that the practitioner's own body is protected by avoiding unnecessary strain. By the Consolidation phase, however, these apparently strict rules are called into question. A tutor demonstrating a specific technique is asked why his feet are not in the position that the students have been taught. He responds by saying that as the students become more experienced, and learn to recognize their own bodily strengths and weaknesses they can adapt their stances accordingly. In another class, the tutor says, 'I know you are encouraged to move the plinths up and down depending on what technique you are doing, but you have to remember that it is not always good for the patient [to be moved about so much].' By the Pre-professional phase, students have become familiar with several techniques to effect a particular tissue change and students are positively discouraged

from incorporating techniques into their treatment of patients in the student clinic that they would not be able to accomplish themselves. In one example, a student was disappointed when a tutor refused to take over and complete a particular technique in the student clinic. He pointed out that his physical stature was very different to hers and said, 'If you won't be able to use it [the technique] in your own practice, then you should be trying to find out what you can do for this type of case.'

Ways of learning

For the students, the careful staging of the development of an 'individual style' involves coping with and negotiating different types of classes and their emphasis on different ways of knowing. In addition, tutors have diverse attitudes about the course and what osteopathy is, which the students develop a critical awareness of in their interaction with them. This can result in different students valuing different ways of learning and knowing in different ways.

Taking again the example of Technique classes, they are taught in a way that largely excludes the 'social' or 'emotional' context in which treatment is given. Teaching focuses largely on the students' ability to manipulate the physical body of the 'patient' (their partner) competently. The tutors who take Technique classes rarely teach in the clinic as well, thereby in practice separating the physical skills of palpation and manipulation, from clinical teaching in which students are expected to take a more holistic approach. This seems to be associated with a tendency within Technique classes to place a unique value-emphasis on more physically dynamic techniques. In particular, HVT (high-velocity thrust) techniques, which are powerful manipulation techniques which produce the infamous 'click' associated with a

number of spinal manipulation therapies, are not taught until the third year, and for students they have a big social build-up. Nevertheless, some tutors do try to play this down, for example one tutor demonstrating a technique to second years said, ‘This [figure-of-eight] is a really good technique that you can use in practice. It is not all about the HVT. *Honestly*, I really use this a lot in my practice (*her emphasis*).’

Student responses both illustrate an adoption of the value assigned to HVT and a resistance to it. Some second year students expressed frustration that ‘all I’m able to do is soft tissue’; however, some final year students fed back to the college that wanted the opportunity to do more advanced work on ‘soft tissue’ techniques that they felt were poorly represented in the Technique curriculum. Students are also able to resist the value assumptions of their tutors around techniques in other ways, such as the use of comedy. For example, some final year students were joking about how one tutor would take any opportunity to show off the fact that he could HVT ‘some obscure joint’. Students are also critically aware of the specificity and emphasis of the skills they are taught in Technique, and would make explicit comparisons with the more holistic and individualized approach taken in the clinic context.

Although, in the classroom (non-clinical) teaching, osteopathic technique was usually conceptually separated from social and emotional aspects of the disease experience and professional practice, these issues were not ignored in the classroom altogether. They were tackled in the sociology and psychology components of CBO, and some of the PC classes, such as ‘Communication Skills’. The first year CBO lectures were introduced with a statement that was a form of justification for the class: ‘We have to know about joints and all that – we are osteopaths and that is our trade – but we need to know about lots of other things too.’ Learning about sociology and psychology, the tutor explained, gave students insights into questions such as, ‘Why

do people come and see an osteopath at a particular time?’ and enables them ‘to understand where the patient is coming from’ and to appreciate that ‘pain is complex and emotional – not just about nerve endings’. Communication Skills classes take place in the second year before students take on clinic cases. The existence of a class dedicated to communication demonstrates that these ‘soft skills’ are not taken-for-granted as purely ‘natural’ skills.

However, although discussions in these classes often drew on individual experiences with patients, the object of study is very much the embodied patient rather than the practitioner, with only cursory attention paid to the students’ own feelings. For instance, the handout at a class on ‘acknowledging emotion’ said

Your patient could be suppressing an emotional cycle with possible harmful effects on his [sic.] physiology. To release this could be a useful part of therapy. But remember, *emotion is messy stuff. Do not take it on if you don’t want to or don’t feel able to at that time, or if you do not feel qualified to deal with the issues that might arise. It may be more appropriate to refer the patient to a different therapist* (emphasis in original).

This provides an interesting tension in its message to students: on the one hand, emotion may be having a serious impact on your patient’s health, but on the other hand, it is not necessarily within your scope for treatment. Indeed, emotion may be ‘messy’, implying uncontrollable and problematic boundaries that do not fit easily into a scientific model of disease. The handout makes suggestions for dealing with emotion such as ‘Try to make space for emotional display’; ‘One technique you can use is called mirroring... you describe to them what you are observing of their emotional state... *confront* the patient with their emotion (*emphasis in original*)’, and ‘You and your patient are different people... do not project your own reactions onto

the patient.’ Although students were instructed about these various approaches, they were not given any opportunity to explore practising them at this stage in order to see how it felt, or to be reflective about any issues it brought up for them. It is, therefore, only once they start to work in the student clinic, where emotion is unavoidable, that the students learn to tackle the complexity of ‘real patients’ and begin to practise reflection, which can be a steep learning curve. (The student experience of the clinic and of dealing with patients is discussed in depth in Chapter Six.)

The student recognise the centrality of the clinical experience; a number of students and tutors referred to the clinic as the ‘heart’ of the College. In one second year class, the lecturer said, ‘At the moment you are swamped by academia – the one positive thing about [this college] is *your clinic* – so take the opportunity to get as much hands-on experience as possible – how you spend your time in the clinic is make or break for this course.’ Similarly, the students are, in general, positive about their experiences in clinic. Although they may have concerns and quibbles, they recognize that this experience is vital for their future careers. One student explained, ‘It can be really tiring sometimes in the clinic, but this is what we are going to be doing everyday when we graduate, so it is a good thing to enjoy it’.

For the students, the development of an ‘individual style’ also involves coping with and negotiating the diverse attitudes of the tutors. In particular, the recent changes made within the profession to the way that knowledge is constructed in order to gain legitimacy and facilitate accreditation have generated a number of divisions within the professional community. Even within this one institution, the division between the dualisms of ‘old’ and ‘new’, ‘traditional’ and ‘modern’, ‘classical’ and ‘scientific’ is in evidence among the staff. A group of students organized an evening lecture about the founder of the College of Osteopathy. The lecturer had explained

how much of the content of the original course was excluded now, replaced with more orthodox medical anatomy and physiology, and this was the subject of many student conversations the following day. A number of the students have taken external courses in osteopathy, at more 'classical' osteopathy colleges in the UK and in other countries, and brought back stories of other ways of working. This promotes a certain level of uncertainty about the knowledge and methods of practice taught within the course. However, this is not always experienced as problematic by students who, drawing on the College's rhetoric, often explain this in terms of all osteopaths having 'individual' approaches. Each student can develop an ability to be open and critical to different ways of practising. 'Health care in general is a bit of an unknown, osteopathy is no different,' one student commented.

The tension in the curriculum between the drive for demonstrating 'scientific' knowledge and a commitment to 'classical' osteopathy is aptly illustrated by the existence of a class called 'Comparative Technique'. The way the students responded to this class demonstrates both their acknowledgement of this tension and their attempts to manage it. The class is taught by a very experienced, semi-retired teacher, but is one of the few courses that is not assessed by examination. In both the standard Technique classes and this class the knowledge the tutors are trying to convey is so deeply rooted in embodied experiences that it is difficult to convey verbally (see Chapter Five for a further discussion of this). However, while in Technique the tutors require students to be able to explain and justify their actions on the basis of their anatomical knowledge, this tutor places much more emphasis on embodied experience. One class focusing on 'fluids' was introduced with, 'It is difficult to understand fluids. Unlike bones, they defy analysis.' To explore the role of fluid in the body, the tutor set the following questions and practical exercises:

- Question 1. What fluid spaces occur to you?
- Exercise 1. In pairs, compare what you are aware of about your shape with the shape that strikes the observer. Consider for each, what part of this shape is due to fluid components?
- Question 2. What allows our body shape to recover after injury or scarring has distorted it? What decides if full recovery of shape will be achieved?
- Exercise 2. Imagine ‘ripples’ could travel through the body in all directions from every surface. Choose in your subject some shape that could be made more comfortable (from its present distortion) and now send such ripples of sensation in such directions as will best point up the awkwardness of the distorted shape. What experience results? Does it change?
- Report back to the class and record in your ‘learning log’.

What makes this distinct from the standard Technique classes, is that not only do students struggle to put into words what they are doing, but, as an observer, it is also extremely difficult to establish exactly what is going on in the interaction between students, because so much of it is about subtle impressions and intuitive responses to the other person’s body. This may contribute to the fact that this class is not directly assessed. More critically, it could be deduced that these classes are not important for the legitimation of the course, and, indeed, one of the students pointed out that the mixed-mode students miss out on this class completely. He felt that this was really unfortunate and showed how little the college valued these sort of classes. However, the continued inclusion of the class in the curriculum does suggest that it is perceived to be valuable to the students to some extent. Interestingly, some students seemed very keen to explain to me afterwards their response to the class. ‘Not everybody gets it,’ one student told me, and another responded, ‘What [this tutor]

teaches is more important than most people realize.’ Trying to get more elaboration I commented that it was very different to the anatomy classes. The second student said, ‘The background of anatomy is essential, but what he is getting us to learn cannot be read in a book. It comes from inside you [indicates his heart/chest] and the patient.’

It may be that certain students, because of their previous experience and beliefs, start the college with this attitude and classes such as Comparative Technique enable them to further explore this, while others take a more instrumental approach to learning. Certainly though, the division between those who embrace the more ‘classical’ and ‘esoteric’ aspects of osteopathy, and those who ‘don’t get it’ and emphasize the scientific basis of treatment is in evidence among students as well as tutors. The students are clearly aware of this (messy) divide, of the limits of the formal education they are receiving at the college and of the changes made in aid of legal recognition. However, they, inevitably, have a great deal of investment in the new syllabus because they are devoting at least four years of their life to it, and so are often more ambivalent. In one of the conversations about the lecture on the founder of the college, I asked of the changes, ‘Was it worth it?’, and one student replied, ‘I don’t think any one osteopath can answer that’. Nevertheless, the students can be seen to be consistently negotiating the boundaries of osteopathy as a practice and profession.

The gradual realization that the apparent certainties of the tutors are an illusion is a key stage for the osteopathic students, who learn to appreciate the value of their own opinions and experience of practising osteopathy. Fourth year students discussing the different styles of the tutors said: ‘You learn that they all have different opinions and come from different places, so you can take what you want from them’; ‘As you get more confidence you realize this, but it was not made clear to us before

we started so it could be quite confusing'. During a discussion between a clinic tutor and some of her fourth year students, she encouraged them to stand up to other tutors if they believed in something that was not accepted by the tutor in question. In this way, the students do learn gradually that, in practice at least, there is value to their own 'individual style' and the wisdom of their own experience. However, the heavy emphasis on assessments does limit the possibility for the expression of 'individual style' as students must be cautious to ensure that they can explain and justify, using appropriate language, what they are doing.

Assessment

As noted in Chapter Three, the osteopathy course is heavily assessed, not only through written examinations and assessed coursework, but through practical examinations of technique and case-taking ability. While legal recognition for osteopathy has bestowed certain social benefits on the profession, it also places increased demands on demonstrating ability and 'safety in practice' in a way that can be independently evaluated. Independent evaluation brings an element of standardization into the training, limiting the extent to which the individuality of students can be expressed. For both tutors and students, formal assessment highlights contradictions in the teaching and learning of osteopathic practice. The response from tutors and students alike is two-fold. On the one hand, they put time and effort into passing assessments in order to 'play the game', yet on the other hand they construct models of reality where assessment and, indeed, the whole college experience has a relatively small place in the wider of scheme of things.

The importance of academic ability is clear from the admission requirements of the college, which offer no flexibility: if you do not have the academic qualifications necessary, you have to do the Access course first. In this way, the types of students doing the course will be limited to those with reasonably strong academic ability. However, as described above, the students rarely value academic ability above embodied ‘osteopathic’ skills. They do seem to be aware of the tensions inherent in evaluating different ways of knowing in the course, but to accept overall that examinations are necessary. This may be because the huge investment they have in the course, financially, emotionally, and in terms of the sheer time that they devote to it, makes it important that they are committed to their learning process.

One student expressed an awareness of the problems of teaching osteopathy by saying:

There are some areas of teaching at [this college], and generally I suppose, where there is a big gap between what information can be collated and conveyed and how it can be learnt, especially the work we do for the clinical exam.

Nevertheless, there is a requirement for students to *demonstrate* ability and understanding of the techniques that they use, and this provides a contradiction between learning and the actual practice of osteopathy. One tutor highlighted this by saying that when teaching students, ‘You have to be able to verbalize what you are doing with your hands – and what you are feeling for when you touch the patient.’ This was, he felt, problematic because ‘for me osteopathy is about letting go of the cerebral and just feeling’ but ‘the assessment process does not allow for that’. He also noted that some students found it much easier than others to work in this way. The younger students straight from school often found it easier, he felt, because they

were used to this way of learning, whereas other students find the course very hard on account of this requirement to verbalize bodily skills.

The need to be able to communicate in examinations their justification for what they are doing puts an additional form of pressure and restriction on the students. A tutor was discussing with his students the Final Clinical Competency exams and was saying that in his opinion there was not enough ‘real osteopathy’ in them, which he saw as being a more expanded version of the therapeutic techniques taught at the college. But a student responded, ‘But we are afraid of using techniques that we can’t explain scientifically. We are afraid of failing.’ In this way, while the students are introduced to the broader classical model of osteopathy, they still, unsurprisingly, choose to pursue the aims of the curriculum, in order to demonstrate ‘legitimacy’ and ‘safety’ and to pass the course.

Interestingly, the students negotiate the assessments in ways which did not always correlate to the rhetoric of the curriculum. In a tutorial discussing the clinical viva, where the students have to demonstrate a range of diagnostic and therapeutic osteopathic techniques, the students recognized that it is part of ‘the game’ to learn ‘how to demonstrate a range’. The conversation then turned to how to prepare for different assessments – such as clinic, concepts, and technique – and one student commented, ‘You have to think in different ways for different tests.’ This problematizes the idea of interrelated ‘units’, and demonstrates that the students can be critically aware of the different ‘ways of knowing’ in osteopathy and understand that they must adopt a variety in order to pass. One final year student said, ‘I sometimes feel like I’m jumping through hoops with the assessments. This year they are flaming hoops!’

There is very little flexibility in the assessment timetable that the students are expected to follow, and the heavy assessment means that students are often looking forward to the next set of exams, or 'hoops'. One of the senior staff members said that 'generally the students are only interested if it is assessed'. While clearly the students were motivated to work by exams (there were frequent comments about 'exam pressure' and a definite heaviness in the college atmosphere around exam time), they also had other priorities. The enthusiasm of some of the students for the unassessed courses such as IMS (cranial osteopathy) and Comparative Technique (discussed above) illustrated the ways in which students were motivated by other factors than assessment. One student even commented, 'I would enjoy Concepts [CBO] much more if we didn't have to take an exam in it.' However, in a tutorial where a discussion about 'all these exams' had developed among the students, there seemed to be consensus in the end, albeit in a rather resigned way: 'But there isn't really an alternative [to exams] because there has to be a standard'; 'I don't think there is a better way.'

Certainly the feedback from assessments could produce positive effects on the students. In a clinic tutorial early in the Pre-professional phase, the tutor said, 'There really is a significant improvement in the quality of discussion here today. You would have all gone up a mark if the discussion had been like this all term.' A student replied, 'I think that the recent [assessment] reviews have kicked our arses into gear.' Significantly, the consolidation of three years of theory and practice for final exams and the intensive summer clinic work at the end of the Integration and Synthesis phase, marked a turning point for the students. In discussions at clinic, a number of students commented how it was useful to consolidate all their anatomy at the end of the third year in preparation for the year of pre-professional training.

However, one tutor warned her students in a tutorial: ‘Up to now you have learnt how to be good students, not good practitioners, in the fourth year that needs to change.’ But most tutors did observe a significant improvement in students’ clinical ability from the end of the third year to the beginning of the fourth, and often commented on it, and explained that in general the students felt more like colleagues when they were in their final year. The students agreed with this: ‘I felt real confidence growing in the summer after the third year, rather than just relying on what the tutors tell you to do.’

Nonetheless, the students and some of the tutors employ rhetorical strategies to minimize the importance of the exams. One tutor says to the students:

Have it in your mind that this here at the College of Osteopathy is an Alice in Wonderland.

You learn before you get here as well as after you leave, and I don’t just mean in the sense of CPD [continuing professional development, which is a requirement for registered osteopaths].

The continuing learning he is referring to is wider than just developing and perfecting osteopathic manipulation techniques, but refers to a wide spectrum of social skills, osteopathic ways of seeing and in the widest sense the capacity for healing. Another common metaphor used was: ‘Doing a degree in osteopathy is like passing your driving test – it qualifies you as competent but you only become a real driver after you’ve passed your test.’ In short, the osteopathy course is designed ‘to give a good grounding’ to the students. This grounding is to ensure safety, and focuses on knowledge that it is possible to legitimize externally, such as academic knowledge of the body, and structural osteopathic techniques. It is perhaps for this reason, that some students welcome the pass/fail nature of the degree. For the students, it was often performance in clinic, rather than in academic exams that defined what a good

or bad osteopath was. Talking to one student, she commented on one of her student colleagues, 'It is really interesting to watch Dominic¹⁰ as he is really confident with his patients. He reassures them and makes them feel at ease by talking through what he is doing. It is so interesting because he got so stressed by all the academic stuff.' Another student commented in a discussion about the BOst course, 'It is so important that the course is pass/fail, it is much better... because in the end those who make the best osteopaths might not be the best at exams and so it is fairer that way.'

Indeed, many of the students realize that they are not getting a full picture of osteopathy. One aspect of this is the focus on structural manipulation, rather than techniques such as cranial and visceral osteopathy, which although introduced during the course, do not form a direct part of the assessments (although may be incorporated into portfolio work, or the Individual Enquiry). One student commented that:

Ultimately I think that the visceral stuff may be much more effective than the musculo-skeletal osteopathy that they teach us here at the College of Osteopathy but I do think that it is a good basis and then you can go on and do the other stuff at postgraduate level.

We can see, therefore, that while students do invest time and energy into passing assessments, and recognize the value of them, they also use them instrumentally, rather than basing their whole sense of worth as an osteopath on the outcomes of the assessments. While the college claims to encourage students to develop their 'individual style', a student tellingly explained, 'It is only once you have left your training, that you can become the osteopath that you want to be.'

¹⁰ All names have been changed to protect the anonymity of the participants.

It can be seen, therefore, that the students at the College of Osteopathy do not accept unconditionally the structure of the course, or the opinions and values of the tutors, but debate and reflect on them, and negotiate the course in ways that reflect their own backgrounds, values and future aspirations. However, they do generally support the move from academic to practical knowledge that drives the curriculum, valuing the embodied skills of osteopathic practice highly. While they recognize the value of their own embodied skills, the development of an 'individual style' is attenuated by the need to demonstrate and be assessed on their knowledge and skills. The students understand the importance of passing examinations and accept it. They work for exams in a largely instrumental fashion, and acknowledge that they make important progress as a result of these ways of learning, but also recognize that 'playing the game' requires underplaying some of the uncertainty and variety of osteopathic practice.

Student responses to the homeopathy curriculum

Most students come onto the course at the College of Homeopathy expecting a very different learning experience from what they have experienced in the past, in part because of the contrast between allopathic and homeopathic practice, but also because they have chosen to study at a college that places explicit value on the non-academic aspects of knowledge, and whose teachers are often interested in the esoteric elements of homeopathy. This self-selection, and the small size of the college (as compared to the College of Osteopathy) is the most likely explanation for greater homogeneity in student responses to the course, despite the wider range of past educational achievement. However, although the students have a strong interest in homeopathy,

and usually positive experience as a patient, the experience of training results in the development of a deeper commitment to the therapy and trust in the homeopathic healing process. By using an embodied analytical approach to student learning, the reasons for this commitment can be explored. However, the students are not simply passive learners of a new framework for healing; the centrality of their own embodied experiences to the learning experience means that they actively negotiate their learning depending on their own areas of interest or desire for self-development.

Course content and structure

Learning at the College of Homeopathy is a less obviously staged experience than at the College of Osteopathy. Although the three years of the course have different themes, the style and content of classes are very similar throughout the course. In addition, individuality and self-determination in learning is valued from the beginning of the course, with students maintaining control over the focus of their personal study and being encouraged to do a great deal of ‘personal’ self-development work.

However, there is still some evidence of clear progression and development occurring as students become more familiar with homeopathic concepts, as they are able to deploy a homeopathic framework for understanding illness and healing, and as they get more experience of working with patients. For the students, negotiating the course generates uncertainty as they learn to explore and utilise different ways of thinking and perceiving the human body and the world that they live in.

Learning at the College of Homeopathy is a novel experience for many of the students. The huge emphasis on self-determination and self-development of the practitioner is very different to the system of learning most have experienced in the

British education system. There are no academic requirements for getting a place on the course, and while most of the students do have degrees or other formal qualifications, many of these, and others without formal qualifications, talked about their difficult experiences of conventional education systems. The course provides opportunities for students to share their experiences in the classes, and the development of appreciation of new ways of interpreting ‘dis-ease’ is a key aspect of the *learning* offered at the college: students learn, as one tutor put it ‘to think and be homeopathic’. As this statement implies, it is not enough to learn abstractly about homeopathy, but the students have to embody this knowledge, they learn to ‘be homeopathic’.

For instance, even the first year which takes as its theme an apparently conventional subject – body systems and organs – is characterized by learning through experience, and holistic interpretations of health and illness. Students are given ‘Anatomy and Physiology’ worksheets for self-directed learning to prepare for these subjects. However, this homework is not checked or assessed, so students are free to explore the subject in their own way, and according to their own timescale. The focus of the lectures is rarely on the biomedical anatomy but on, what is termed, the ‘Energetics’ of the system or organ in question. This includes looking at the mental and emotional correlates of the system or organ by drawing on a range of medical, spiritual or psycho-somatic models. In addition, specific diseases and symptoms are considered from the point of view of homeopathic prescribing, which aims to build up a very detailed picture of the person’s specific illness experience, and includes mental and emotional symptoms as well as physical ones (see Chapter Five for more detail).

By participating in these classes, students learn new ways of perceiving and framing illness experience. For example, in a first year class on ‘Lung Energetics and

Therapeutics', the tutor took the students through a guided meditation 'to see what we feel'. A guided meditation is where students close their eyes, relax and follow the words of the guide (tutor) to see what they experience. Briefly, the meditation was to feel 'the breath flowing in and out of the body' and see how it felt. Then each person was to bring to mind someone they knew with some kind of respiratory problem and see if that changed how they felt. Then, to finish, the tutor got everyone to come back to a place where they felt that the breath was flowing smoothly and effortlessly again. After the meditation, students discussed their experience with a partner, especially of the 'respiratory problem' stage of the meditation, and then fed back to the class as a whole. The tutor wrote key words on the board, which included 'tighten', 'closed', 'hunched', 'not enough', 'limits the breath', 'limits abundance', 'sad', 'frightened', 'panic', 'closed', 'laboured', 'pain', and 'constriction'.

The tutor then talked through some of the cultural meaning of respiratory illnesses, and how different medical systems view the lungs. These included the traditional Chinese system where the lungs are believed to hold the grief of the heart, traditional British expressions such as 'Old Man's Relief' to describe pneumonia, the concept of asthma as 'smother love', and work by Louise Hay (1994; 2002) on mind-body connections, which says that pneumonia is often 'tired of life'. According to the tutor, making connections between physical illnesses, emotional conditions and the social environment was key to the understanding of the 'energy' of the lungs. The tutor said to the students, 'Even if you just felt the physical stuff [while you did the meditation], at least intellectually you can make the connection to the emotional stuff, even if you can't feel it. But in two years you'll all be whizzes on it!' The class, therefore, provides an opportunity for students to begin develop a new framework for

understanding illness. ‘Progression’ occurs gradually as they are able to make (and feel) these connections with greater ease (become ‘whizzes’).

Identifying connections between emotional and physical aspects of experience were often extended beyond the individual case, to an appreciation of the wider social and political condition. Taking the example of the idea of asthma as ‘smother love’, the tutor stressed that this is only one possible connection: ‘Asthma *may* be due to having an overbearing or overprotective mother, but you shouldn’t assume it. Get the patient to tell you their experience, and see if it is a relevant interpretation.’ She then went on to say that it is possible to make that link in terms of wider social and political trends. She argued that in a culture where children are becoming increasingly protected due to a climate of fear, that it may be unsurprising that asthma is on the increase. She then said that whether one child gets asthma or not is all about *susceptibility*. She explained:

Susceptibility is a key concept in homeopathy. Medics can’t quite get their heads around it, but then if you look at the vested interests [drug companies] in looking outside and not inside, you can see the reason [why the homeopathic approach is not used more].

For some of the students, this more political interpretation of health care is familiar; for instance, a number of the students were involved in various forms of activism, and they welcomed this kind of debate. For others, the political side was new, but tutors were not afraid to put their own opinions across, thereby promoting thought and discussion among the students in and out of class.

Tutors regularly engage directly with orthodox medical or ‘allopathic’ perspectives. This tutor explained that, on one hand, it was important to study biomedical definitions of illness: ‘I want you to have enough information so that

when people come in [to a consultation with you] you know what they are talking about... It is important for you to understand, so you are speaking their language. It takes away fear.' Nonetheless, she concluded, 'From our point of view the names don't matter. Don't be scared by the labels, so then you can feel empowered and treat this [points at the board where the notes from the meditation were recorded, and waves particularly at the emotional stuff].' This class provides a good illustration of the way that the education process is a site for boundary setting between allopathic and homeopathic practice, often couched in terms of 'us' and 'them'. It also indicates that part of the students' (subtly staged) progression through the learning experience involves becoming more aware of the ways in which homeopathic thinking is differentiated from orthodox medical thought. Sometimes these discussions caused tensions and debates in the classes, especially in relation to controversial topics such as vaccination and the use of allopathic drugs in cancer treatment demonstrating that the students brought their own attitudes with them and that the learning environment allowed for the expression and processing of these diverse attitudes.

Beginning in the second year, students begin to attend student clinics and so further develop their skills of homeopathic analysis. The details of the clinic work will be explored further in Chapter Six along with its implications for power relations between patient and practitioner. However, here it is important to appreciate the centrality of the clinic experience for the students. One student expressed the experience of coming to clinic and taking cases as, 'It's like growing up.' In this way, the move from first to second year is very significant to students, but can also bring them new challenges. One student expressed the difference between first and second year as, 'In the first year you are all in the same boat as beginners, and everyone is all excited about this amazing stuff we are learning, but in the second year it has become

a bit strange sometimes. Some people in the class seem to be comparing themselves to others, especially about how many cases they are taking.’ The clinical training provides an opportunity for the students to take cases and analyse them in a structured and supported environment, or to simply observe others, and forms the basis of their own production of a homeopathic professional identity.

Ways of learning

Learning about being a homeopath at the College involves not only a new way of thinking about the body, illness and healing, but the *incorporation* of homeopathic ways of healing. Personal experience is highly valued in the learning environment at the College of Homeopathy because it develops student’s own awareness of their personal sensitivities, and this is considered a key component in reflective professional practice. Students are required to apply the homeopathic healing framework to their own lives, which means that students are able to experience its effects thereby deepening their commitment to homeopathy. Indeed, students are ‘warned’ that they will ‘transform’ themselves during the course. One tutor explained this by saying that the College provides ‘a safe place to transform and grow’. It is for this reason that students find their personal experiences being valued and validated in ways that may be unexpected in an educational environment.

Generating an emotional response in the homeopathy students (and explaining it within a new framework) is understood to be key aspect of learning things in an ‘embodied’ way rather than purely academically. Often tutors evoke emotional responses through language, imagery and narrative (cf. Denzin, 1997 on the ways that ethnographers do this when writing). In this educational setting, storytelling, in the

form of case studies or personal experiences, is a key tool to facilitate students getting a ‘feel’ for, what is often termed, the ‘essence of a remedy’ in Materia Medica classes. In one class, the tutor poses the question to the students: ‘How do you differentiate between learning academically about remedies and *knowing* about them?’ She says that the key is to ‘combine mind and heart, intellect and feeling, and when you come to a balance that is *knowing*’. In practice she suggests that in order to know a remedy you need to focus on your body as well as mind: ‘Be with the energy [of the remedy] and start embodying it and so knowing it’... she suggests that when reading about remedies ‘pause, then work out how you feel about them, because that is where the empowerment lies’. In this way, it is clear that at this college the tutors believe that learning should be more than the acquisition of new facts, but a deeper connection that *incorporates* the knowledge about the remedy. Throughout the course, the students begin to voice these values too. In another class on the remedy ‘Staphysagria’, this was taken further to bring in the embodied experiences of the students who gave examples of the ways in which they had taken or administered the remedy. For example, one first year student spoke movingly about her experiences of miscarriage as the others listened to her, and after she had finished speaking, the tutor thanked her, and slowly turned to the class and asked, ‘Can you feel the energy of Staphysagria now?’ It is difficult to put words to the atmosphere in the class at the time, because it was a mixture of emotions, such as sadness and grief, experiences, such as violation and pain, and bodily responses, such as tears, but the students responded with ‘yes’ to the question.

Self and professional development is given a lot of weight in the curriculum, such as through the inclusion of Personal Practitioner Skills classes that explore topics such as ‘sympathy and empathy’, ‘safety and trust’, ‘personal baggage’, ‘money’,

‘body language and voice’, ‘anger’, ‘consulting room dynamics’, ‘honesty’, ‘rescuing’, ‘intuition’, and ‘death and dying’. A variety of teaching methods are used in these classes, including practice consultations in pairs, guided meditations, shamanic journeying and discussion. The tutors do not, however, use role play as a teaching tool; students practise on each other. This is because the College believes that it is important for students to understand what it is like to go through the experience of a homeopathic consultation. It may also be because role play serves to decontextualize case-taking.

Perhaps most tellingly, reflective discussion about various issues regularly emerges spontaneously in classes. For instance, in a second year class on ‘Conception, miscarriage and termination’, one student volunteered her own experiences of miscarriage, and said that a couple of years ago she would not have been able to talk about it without crying. The tutor said that it was incredibly important to explore your own sensitivities as a practitioner to ensure that you are doing your best for the patients, rather than being ‘stuck’ in your own emotions. The tutor recounted her own experiences of termination, and shared with the students that it was not until she faced patients in her clinic who had also had terminations, that she realized the extent to which she was still grieving.

The tutors positively encourage the expression and processing of emotions within the educational setting. The approach to managing patients’ emotions that students at the College of Osteopathy are taught in advance of clinical practice, described above, seems sterile in comparison to what happens at the College of Homeopathy. However, while the ‘self-development’ emphasis of the course provides opportunities for personal healing, it can be extremely challenging for students, and many of the participants in this study experienced huge personal

upheavals or emotional challenges at various stages of the course. Students are encouraged to regularly see a homeopath during their training, and to record their experiences in their learning journal, in whatever artistic or linguistic form best expresses them.

Taking as an example a class addressing ‘Separation and Grief’, there is clear evidence of the explicitly embodied approach of the teaching, which stresses the value of experience and empathy. The tutor got the students to sit in a circle and began a guided meditation, while the group connected hands. The meditation included suggestions such as ‘feel your connection with the earth; imagine roots coming out of your feet into the ground; and feel the flow of energy moving around the circle from right to left, clockwise’, and then ‘bring your attention, seeing how each one feels, to a part of your life where you feel connected [long pause] and then bring your attention to another part of your life where you feel disconnected [long pause]’. At this point one student started to cry, and another started to cough, which she later described ‘as if I was trying to cough something up’. No one in the class tried to curtail these embodied expressions of the experience. After a while, the tutor suggested, ‘Choose an affirmation [a present tense statement] to find a way to reconnect with the parts of our lives where we feel disconnected’.

The class was then divided into groups of three to discuss how the meditation had gone and afterwards the group reassembled to share ideas and experiences, and reflect on connection and disconnection more generally. Subjects that came up in the discussion were disconnection with husband, disconnection with mother, disconnection from work colleagues, and disconnection with the left side of the body. This latter example came from a city worker who interpreted this as being out of touch with her feminine and creative side – she had been having pain on that side, and

the sensation of being numb along her arm and shoulder – she said that after the initial meditation all the pain was gone, and that not only had the energy ‘filled her arm up’ but that she felt she had enough to pass onto the next person. She commented that she usually felt quite uptight but that at that moment she felt joyful, relieved and a little surprised at herself for how open she was being with the group. Lastly, the tutor talked through some different grief remedies, and the different expressions of grief that they were associated with.

The response and feedback from the group demonstrated that the students were able to critically negotiate and respond to the class in creative ways. Within the class comments included the fact that when discussing the experience within their groups of three, there was no judgement, that everyone’s uniqueness was accepted which allowed everyone to feel safe in the setting. For example, people could cry or express their feelings without everyone trying to help them or stop them crying but just by being there and witnessing their experience. This ‘witnessing’ is part of what the tutors say they are trying to convey to the students about what is involved in effective practice, and by actually doing this in class the students can come to an appreciation not only of ‘how’ to do it, but of what the impact can be in the healing process and in the relationship between patient and practitioner. Another student said that she felt that, ‘In the outside world we often sit in our boxes and put other people in boxes and it is easy to make judgements about people,’ but that here in the college ‘you can really see how everyone is the same.’ This observation links to ideas about ‘holding the space’ for clients – a place with absence of judgement and witness to a person’s experience whatever it might be. These two tropes – witnessing and holding the space – will be explored further in the Chapter Five, but here it is important to recognize that the intended effect of these exercises is that student should have the

opportunity to practise these embodied skills and experience their effects so that they are able to recreate it in their own practices.

After the ‘Separation and Grief’ class there were some mixed feelings. One student felt particularly drained by the experience, and three others spent time talking to her during the break. The group was discussing that it must be very difficult to lead a class like that. They were torn between a recognition that it was useful to do those kind of exercises, but that in a group that big it was not possible to deal with everyone’s needs. Nevertheless, the students were extremely supportive of each other outside of the class as well as in class.

As the students become more accustomed to the content of the course and the teaching styles of the tutors, they begin to enjoy and appreciate the experiential components of the course more. The rhetoric behind these teaching methods is that ‘homeopathy is an energy medicine’, in contrast with medicines that use material substances that ‘force’ change onto the body. In order to teach students to practise ‘energy medicine’, the tutors use a deeply embodied approach, which comprises of both encouraging students to explore the course material using all their bodily and emotional faculties, and to develop a reflective awareness of their own responses to remedies and health issues. For instance, the curriculum includes Chi Kung, which is a form of oriental movement-energy work. The tutor explained, ‘These classes allow you to experience energy, and energy is what we are working with in homeopathy so you need to know what it feels like.’ While some of the students have done this or similar body-work before, for others it is completely new. One final year student said to the Chi Kung tutor, ‘In the first year I had no idea why we were doing Chi Kung, to be honest I thought it was a bit weird and didn’t really ever feel anything, but now I

really appreciate how important it is... I wish I could go back and do all those classes again!’

We have seen that the experiences of the students at the College of Homeopathy are unique and that the College draws the personal and the embodied very firmly into the centre of the learning experience. For the students, bringing their own personal experiences to the college environment is both welcomed as relevant and healing, but is also experienced with some ambivalence as the personal issues that are raised in class sometimes are not always dealt with fully, and students can feel destabilized by them. Some students choose not to share things in class, which may constitute a resistance to the imperative to share, but this choice was always respected. The value assigned to interactional skills by the College is largely mirrored by the students, although the students also enjoyed the more ‘fact’-based learning.

Assessment

The college states there is an aim to provide education ‘in an atmosphere of mutual support and encouragement and with an absence of pressure to perform’. However, there must clearly be some way of assessing student learning, but what is avoided in the college is formal examinations. Students are required to construct a ‘learning journal’, to submit five written case studies, and are assessed by tutors on tutorial and clinic performance. Student’s responses to the assessment indicate a complex evaluation of relevant skills for homeopathic practice, and their difficulties in taking a self-assessment approach.

A comparison between an 'Introduction to Learning Journals' session for the first years on their first college weekend, and a session for the students who had just begun their final year provides an interesting insight into the way the students respond to the use of Learning Journals. The first year session began with an introduction from the tutor, and she asked the students to give a little introduction about themselves in turn. In response to what they said she asked questions to attempt to delve more into their style of learning, such as, 'How would you know when you have learnt that?' One response was, 'When the first person comes to me and says "Thank you",' which the tutor point out was a form of 'evidence' of learning. Another student talked about 'practical philosophy' and her practices such as meditation: this the tutor summarized is an 'integration of learning, which takes place on an unconscious level and is demonstrated through altered behaviour'. The tutor wrote a number of the 'things that help us learn' on the whiteboard including 'beliefs', 'values', 'pain', 'not knowing', 'mystery', 'interest', 'crisis', 'real-isation'. The tutor said that she felt that using 'fear' to teach students is about 'conditioning not learning', a statement which was supportive of the college policy not to assess students through conventional examinations. Similarly, it was stressed that at the end of the course the Learning Journal would be 'appraised' and 'it is not about judgement or assessment, we want you to think critically about what works for you'. Finally, the tutor explained, 'Your relationship with the journal is important for you to establish. It can be of any form, and it is up to you to negotiate your personal boundaries around it.' The final appraisal of the Learning Journal is conducted on the final 'Completion' weekend of the third year and is a private session between the student and one of the tutors. Explicitly, and in the way that the Learning Journal is presented to students, it is clear that knowledge and learning is considered to be

something that is contextualized in the individual's life and yet interrelational in terms of the importance of observing other's experiences and being non-judgemental about them. Again, the emphasis on learning through experience to deal with others' emotions was brought up by the tutor, 'Have an absolute respect for pain and its role in both healing and learning. To be able to be a witness to another's pain can make them feel that they are being validated.'

The flexibility of the ways in which the Learning Journal can be constructed was nevertheless experientially troubling for some of the students. Questions such as 'So are we supposed to keep the academic and the personal parts of the journal separate?' were met with a moment of silence, a shrug, and 'It is up to you' from the tutor. In one conversation after class a student commented afterwards to her classmates, 'I still don't really know what we are supposed to do.' Another replied, 'I don't really think there are any "supposed to"s. We can do it however we want to.' The absence of clearly defined rules and expectations provides a stark contrast to the kind of educational environment most people experience at school and in conventional education. On one level, this requires that students take responsibility for their learning, which was apparently the impression the tutor was trying to get across with her shrug. On the other hand, this represents for some, although by no means all, of the students a difficult educational transition to handle.

The third year class showed the ways that some of the students had handled this approach. The class began with students dividing into pairs to discuss their progress with the Learning Journal, by answering the question, 'Where are you now?' A huge variety of answers came back to the class after this discussion, such as 'positive and moving forward', 'in a state of externalizing panic', 'getting out of my head to the visual and the material [from a student who was doing some pieces of

artwork as part of her journal]', 'moved from confusion to clarity', 'I'm ready to integrate the parts of my journal', 'I'm going to do a painting to represent the journey I've been on with this course', 'we were talking about the importance of self-approval and acceptance, to be able to say "I am enough", and I've had to let go of my expectations about this journal'. While a couple of students still seemed to be experiencing doubt and confusion about whether they were doing enough or the right thing, most were talking about their journals with confidence. One student explained that she was happy now with her journal and just saw it as part of an 'ongoing process' to be continued beyond graduation, but that she was still anxious about the cases she had to submit.

The submission of cases is the most conventional aspect of the assessment, with students being issued with 'Guidelines on submitting cases for presentation' (see Appendix 6). Students are required to submit five cases, of which one can be an acute situation. The following is the recommended structure for the presentation of cases: initial case history; chief complaint/s; other current health problems and concerns; mental/ emotional symptoms and general personality type; general medical history and important biographical events; family history; observations; case analysis; treatment plan, and two follow-up reports, with analysis and treatment plan. Cases are submitted one at a time over the final year, with feedback from the tutors. The criteria for assessment of the case studies includes the ability to obtain sufficient relevant information during case taking and present it clearly; to understand what needs to be treated; to evaluate the symptoms; 'the ability to be able to translate the language of the client and the symptoms of the case into repertory rubrics'; to differentiate between different remedies that may be relevant to the case; to justify the choice of remedies, potency and repetition; to be able to decide on an appropriate

timetable for the case management, and to give a prognosis; to suggest any additional treatment, such as flower essences, or lifestyle and dietary choices, and finally, in follow-up appointments ‘the ability to appropriately evaluate the responses to the remedies that were prescribed’. This is a much more structured mode of assessment, with clear expectations, and independent evaluation. In addition, students get detailed feedback on their cases, and may be asked to revise them before they pass.

The students at the College of Homeopathy generally seem less willing to ‘play the game’ in assessments than the students at the College of Osteopathy. This is understandable as a response to the Learning Journals because there is not a ‘game’ as such to play, since each student is encouraged to produce a completely individual journal. However, in the case studies, the students must learn to play the assessment game and give appropriate information and demonstrate skills in analysis to pass. The tutors often had to encourage students to develop their skills in producing pass-quality case studies, and to adapt ‘what happened’ accordingly.

The Learning Journal and the case submission produce different concerns and anxieties amongst some of the students. The key determinant is whether students experience more difficulties with being externally assessed (will another person think what I have done is good enough?) or internally validating themselves as knowers and practitioners (do I believe that I am good enough?). The College provides a lot of practical support in the development of skills necessary for case analysis, particularly in the tutorials and student clinics, which are discussed further in Chapter Six. For the Learning Journals, the students demonstrate an incredible range of creative talents, and a deep reflective understanding of their learning process. The creativity and passion in the final Learning Journal presentations demonstrated that they embraced the process.

For instance, one student created a series of figure paintings representing her progress throughout the course. These atmospheric paintings put her emotions and experiences onto canvas, and some of them incorporated symbolism. One was a small pale blue and grey portrait-style picture painted a few months into the course, which represented her feeling of being, what she described as, 'totally disconnected'. Another painting, the last in the series, was a huge canvas over a metre tall of a woman with Egyptian colouring and clothing style, with the image of a baby growing inside her. The chakra points on the figure are golden. The image is incredibly powerful on its own, but in contrast to the earlier paintings and by observing the progression of these (self) portraits it is clear that the student had come a long way during the period of enrolment on the homeopathy course. Another student, who was also a professional musician, composed a piece of music that she played as part of her learning journal. A theme that recurred for a number of the students in the 'personal' part of the journal was that it represented for them the key obstacle that they encountered during the course. For one student, this was centred around her belief that 'I thought I didn't have a creative bone in my body. My mother can do anything [creative]. I knew I wanted my journal to be bright and colourful. I didn't know how, and I certainly didn't know anything about embroidery [at that time].' This student has done a series of embroidered pictures and lino prints that represented parts of her journey, such as an elephant that has been a animal she had connected with on a shamanic journey. She said, 'I'm very good with words. I've never had any problem with that, but the creative stuff was my challenge.' Another student explained that 'The Learning Journal has been central to my experience here [at the college]. My journey wouldn't have been the same without it. It gave me a form of support outside the college weekends. On the weekends everyone is so supportive, but sometimes I

felt quite alone back in my other life.’ He explained that it was vital for him that the Learning Journal was undirected, while also being a formal requirement.

My core issue was about self-validation – *I am enough* – the structure of not having guidelines caused problems too because it brought up all sorts of things about whether I was doing it right or if I’d done enough... but this ended up being the key thing I’ve learnt from the course. My Materia Medica may not be as good as it ‘should’ [makes inverted comma signs with his hands] be, but now I have realized what I will be able to do with people who are attracted to work with me... I have a clear idea now.

He produced a ‘medicine shield’ as part of the Journal which he said represented ‘This is who I am, what I have to give’.

It was clear that the absence of conventional examinations did not free students from expectations, but that the expectations were generated from within themselves. Many explained to me that they found this process of validating themselves to be a huge emotional challenge, but were invariably very positive about the experience at the end of the course. The extent to which the students’ embodied ways of being-in-the-world changed varied, but many students in Learning Journal sessions and in informal interactions shared their feeling of new-found confidence and self-acceptance. For some, the ‘transformation’ was even more obvious, with people leaving unhappy marriages, having babies, or radically changing their appearance. These experiences were validated as being an inseparable part of the process of embodying homeopathy, of ‘being homeopathic’. As one tutor put it, ‘The only thing that you can be certain of [on this course] is change. And you can pass on this journey in the way you work with clients.’ Just as admission to the college could be on the basis of life experience rather than academic qualifications, the process of

learning was seen to impact on all aspects of the student's life not be simply the acquisition of facts, hence the personal component to the learning journal.

Clearly the College of Homeopathy aims to encourage individual creativity and accept the individual experiences of its students. A number of students at different stages of the course commented that they appreciated that tutors saw them as homeopaths right from the beginning of the course. As one tutor put it, 'From the moment that you stepped in the door last weekend you were homeopaths, learning your trade but already homeopaths.' Nevertheless, an exploration of the development of a 'homeopathic' identity is not redundant; the importance of demonstrating competence in practice is crucial and they must learn to be able to deploy homeopathic concepts and frameworks. It may be that there is simply a large degree of heterogeneity within this identity¹¹, but with some convergence in philosophy, values, and graduating student's skills in case analysis. Students are not permitted to be passive learners in this environment because they are required to delve inside themselves for the self-reflective aspects of the course, and they have responsibility for assessing their own progress.

Conclusion

This discussion has demonstrated that students actively negotiate and engage with the different stages and components of their learning experience. Students develop new values, embodied skills in interaction, and ways of being in the world. We can see that in both colleges (despite it being less formalized in the College of Homeopathy), that students are required to approach embodiment and healing in certain ways (while

¹¹ This may be particularly relevant in a discussion about the professional identity of graduates from different homeopathic colleges, or medically qualified homeopaths.

other frameworks are not validated). Nonetheless, there is diversity and debate within each profession and the students are able to contribute to that. The students' own process of experiencing and analysing bodies in health and illness, and their negotiation of the uncertainties and tensions in the profession, contributes to the development of their own professional identity.

What this chapter demonstrates is that the learning experience can not be simply explained as a process of passive socialization into a profession, while clearly the influence of teachers and the structure and form of the knowledge presented in the curriculum is deeply influential. The students' embodiment is deeply and explicitly implicated in the learning process. For the homeopaths, their own biographies and healing processes serve as an integral and acknowledged component of their learning. In class, they explore first-hand the kinds of emotional responses that they are likely to encounter in practice, and are encouraged to explore and reflect on their responses to this. For the osteopaths, their lives outside the college are not explicitly recognized in the assessment, even discussion of the reflective portfolio tends not to stray outside the spatial and experiential confines of professional practice. However, their individual bodies are at a very tangible level vital to the learning of knowledge and skills for their practice. Learning, then, is about changing embodiment and ways of being in the world, not only changing patterns of thought.

FIVE

Learning the ‘theory’ about the healing process: from body-talk to body-stories

Introduction

During the training, student experiences are spatially and temporally divided between ‘classroom’ and ‘clinical’ encounters. As the previous chapter explored, the students negotiate these different loci of learning in different ways. The data for this chapter will be drawn from classroom encounters, rather than those in student clinics where students come into contact with real patients. The knowledge learned in the classroom can be academic, embodied and/or emotional in form, depending on the class or the college. Classroom teaching, however, avoids many of the uncertainties of clinical training, and so can tend to reproduce ‘ideal’ models of the healing process and the therapeutic encounter. This chapter explores the way in which students, in these classroom encounters, learn the ‘theory’ about the healing process.

Students at both colleges learn to be practitioner-actors that, in varying ways, use narrative as a key tool to investigate, analyse and treat cases of ill health.

Students slowly modify and then normalize, first, their ways of listening to the embodied patient and, second, their ways of analysing how to treat the dis-eased body. I explore these two aspects using the concepts of *body-talk* and *body-stories*, neither of which are *in vivo* concepts but are useful to bring together and theorize

some of the key observations in classroom encounters about the healing process and practitioner and patient embodiment. The ways in which students learn to listen to and interpret bodies clearly has implications for the embodied patient, but the student's bodies are also made explicit in the learning environment (and healing process), through the development of embodied and reflective skills.

Body-talk: learning to listen to the sick body

Understanding how students learn to investigate the 'dis-eased' body (case-taking) gives insights into both the nature of the 'bodies' that are envisaged in the healing process and the character of the embodied interaction in the therapeutic encounter. To this end, I will consider the various ways that students learn to listen to 'body-talk' (the communicating embodied patient) and examine the role of these activities in the healing process.

Osteopathy

The osteopathic student learns three main ways to listen to and communicate with the embodied patient: *oral case taking*, *palpation (touch)* and *observation*. These three tools form a triangulation method for the students to listen to body-talk. The development of palpatory skills is assigned the most time and value within the course. Touch is the cornerstone of osteopathic practice and, as such, becomes the dominant way of listening to the body that the students adopt. Nonetheless, the other ways of listening are also included in some detail in the teaching content.

The skills of *oral case-taking* are covered at a number of points throughout the course. They are developed in practice in student clinics, but before then students are required to become familiar with and adept at using the standard 'patient records form' that the College uses for clinic records. The rationale and content of the case history section of the form is explored in various classes, including those covering anatomy and pathology, Communication Skills classes and Conceptual Basis of Osteopathy classes where the social and psychological impacts on health are taught. Students are required to use the standard form when taking a case, which means not only that they always ask the patient questions in the same order, but that they have a standard size of 'box' in which to record the responses. The 'case history' part of this four A4 page patient records form includes basic patient details, including occupation and leisure pursuits, presenting complaint, current general health, sleep pattern, medication, serious illnesses, operations, past accidents, and daily pattern of pain. The students then take a detailed medical history of the patient, including GI tract, ventilatory, cardio-vascular, neurological, allergies, dermatological, G-U tract and micturation, menses/gynae, and obstetrics. There is also a box for domestic responsibilities, children and family history. Finally there is a (very small) box entitled 'Patient's view of their problem'.

The most common teaching strategy used for oral case-taking is role play: students are given theoretical 'situations' where they play the parts of the practitioner or the patient. Students also have the opportunity to be videoed taking cases. Through repeated practice of case taking, the student osteopaths learn what to listen for, how to ask appropriate questions, and how to balance listening and writing down relevant information. Their skills of interaction gradually become more effective and efficient for obtaining the information that they require. Oral case-taking is perhaps

the most obvious way in which an embodied patient is able to communicate his or her lack of well-being – through a *linguistic representation* of dis-ease, usually either in narrative form or as a direct response to questioning. Indeed, in clinic the students are asked to provide ‘hypotheses’ about the osteopathic diagnosis after taking the case history before they begin to palpate the patient. However, there are significant limitations to the patient’s control over the narrative because of the linear ‘order’ that is required by the form that the student osteopaths have to fill in.

The second method of listening to body-talk is *palpation (touch)*, which, at the College of Osteopathy, is easily given the most time and attention, and is the most heavily assessed of the three methods. It is important to understand that there are at least two elements that contribute to acquiring skill (according to the College) in palpation: an academic knowledge of anatomy and physical motor skills. There are a number of reasons that can be used to explain this, which revisit issues raised in previous chapters. Firstly, the founder of osteopathy began his development of the therapy through exhaustive research into human anatomy. Secondly, and more critically, in order to get government recognition for the profession it was necessary to demonstrate that students would acquire a sound grasp of anatomical science, physiology and pathology. Thirdly, in order for students to be able to be assessed on their ‘Technique’ they have to be able to explain what they are doing, and a common anatomical language provides a way of doing this that is easily cross-referenced between students and tutors/examiners.

The learning of palpatory skills blurs the boundaries between the value of apprenticeship (or midwife-teaching) and conventional mode of imparting knowledge (or banker-teaching). One osteopath explained, ‘I honestly believe that you can’t teach osteopathy. You can get the basics of anatomy, but then the only real learning

you do is in your own practice.’ In this way, the explicit teaching of motor skills can never replace self-discovery or apprenticeship (Archer, 2000: 166). There was repeated evidence that learning embodied skills was something that only the students can do for themselves. Tutors frequently made statements of this kind to the students, such as, ‘We can only try to get you to feel what we feel. We can’t feel it for you!’

Yet palpatory skills are explicitly taught at the College of Osteopathy, in a formalized, linear process. This process begins with the learning of anatomy (Structure/Function), and pathology (Function/Dysfunction). This provides the students with a visual model and a common language to work with. The second stage is to begin to ‘get a feel’ for the structures of the body, though courses such as Interactive Anatomy, Structure Function tutorials and first and second year Technique classes, which focus on students familiarizing themselves with what ‘normally’ functioning bones and tissues (muscles, fascia, and to a lesser extent viscera) feel like. This is done through guided and repeated touch and exploration of bone specimens, and each other’s living bodies. These classes begin the move away from the purely ‘theoretical’ anatomy as students gain an embodied appreciation of the lived body. The third stage encourages students to become familiar with non-‘normal’ bodily states, and during the final stage students are required to adapt their osteopathic techniques both to the requirements of the individual patient and to their own bodily capabilities.

The development of ‘palpatory skills’, according to one student ‘basically means to see with your hands’ and Technique classes provide the space to practise doing this within the College. Students practise their palpation and osteopathic adjustment techniques on each other. This means that students’ own bodies are deeply implicated in the learning process, not just in terms of developing new bodily

skills but also by playing the role of the patient. As one tutor put it, 'You need to do it and have it done to you to understand it, before you try it on a patient.' During this time the day-to-day 'absence' of the lived body (Leder, 1990) is brought into sharp relief for the students. The awkwardness of learning to do something new and unfamiliar with the body sharpens the awareness of it. In Technique classes, students gather round to watch a demonstration of the techniques, then return in pairs to their plinth to palpate the area in question and test the techniques on each other. These are fairly quiet classes, as the students work together in pairs palpating the bones and tissues of their partner. However, they are not silent; the 'talk' includes the 'patient' feeding back his or her experience and the 'osteopath' asking for more direction or help. For instance, one student was used by the tutor for the demonstration of a technique in front of the whole class. Afterwards, she was feeding back to her partner, who was practising the technique, trying to explain what felt different, 'It is amazing, his [the tutor's] touch is so light.' The tutors circulate in the room offering advice and sometimes re-demonstrating the technique to pairs of students.

The embodied participation that is expected from the practitioner in a consultation is not simply at a surface level at the point where they touch the patient. In conjunction with palpation, students are expected to develop 'proprioceptive' skills. This involves the practitioner bringing as much of his or her body as possible into the palpatory activity, for instance, by using hands at arms length so that you 'bring in the shoulders to the equation'. A tutor explained, 'Your palpation will be better if you use some body movement... even though it is a tiny little bone you are working with.' A student explained to me, 'The sensors in the joints and muscles inform us of where we are in space, which gives us more information about the patients. It is particularly important for feeling the *quality* of the movement.' In this

way, the student, using physical sensation throughout his or her whole body is able to 'see' into the patient with his or her hands. This interactional quality of the encounter means that both practitioner and patient embodiment is crucial to understanding the practice.

Students have to be able to evaluate the physical condition of their 'patient' (partner) but embodied observations, such as 'quality' of movement or of tissues, are not easily expressed through language. While anatomical language is often used as the basis for discussions, in practice it is clear that some body-talk is not translatable in these technical terms. In one second year Technique tutorial the tutor was demonstrating a technique for adjusting the wrist: 'What I am trying to do... this is really hard to explain... through my fingers and thumbs I'm trying to focus the movement... put the movement through that particular bone.' The students joked, 'That's osteopaths, not very good with words!'

Sometimes the tutors offer advice that students should connect their experiences with and draw on their anatomy knowledge; for instance, in a fourth year Technique class on the ribs, a tutor said, 'Just feel for it, try and visualize what is happening'. However, often, the embodied knowledge that the tutors are trying to convey is not so easily codifiable or abstracted. Language must be manipulated through metaphor to make it useful for explaining techniques. For instance, one tutor explains, 'If you imagine a beach ball in the water and you are trying to push it underwater and it is resisting – that springiness – that is how the muscle should feel.' Additionally, tutors' descriptions often involve verbally orientating the students to their 'patient' at a bodily level and in terms of the outcomes of a movement or touch. For example, 'You are going to rotate the pelvis, then you will be dropping down into the pelvis which is already rotated.' When tutors are demonstrating a technique often

they can not describe what they are doing at the same time as actually doing it, as this excerpt from field notes written during a Technique class demonstrates:

The tutor's eyes seemed to glaze over when she was demonstrating the technique. She had to stop what she was doing to explain to the observing students what they would have to do to get the technique right. While she was actually feeling for the tissues and locating her own hands and body in relation to the body of the student model, she seemed entirely focused at that point of bodily interaction. But for her students it was necessary for her to take a step back and orientate them.

There is clearly some tension between the embodied skill of palpation and a linguistic expression of that skill.

These examples demonstrate that despite the explicit teaching of palpatory techniques, much of the learning happens at an unconscious embodied level, which supports the potential value of habitus as an explanatory tool to explain the changes that occur during the learning experience. Learning is a gradual move to familiarity with the tissues and with the experience of what it *feels* like when bodies in different physical states *interact*. One student said, 'You know so many techniques and you don't know how you know them'. 'Playing' the roles of osteopath and patient is fundamental for the learning experience. It is through repetition that the students develop their palpatory skills. This parallels Mead's account of the emergence of the self, because play is also fundamental to the development of a sense of intersubjectivity and an ability to be reflexive (Crossley, 2001: 144). An ability to be reflective about their practice is vital for the students, and role play allows them to put themselves 'in the shoes' of the patient thereby contributing to the development of

empathy. As one student thoughtfully put it, ‘Self-awareness comes from doing not thinking.’

The students and tutors use one of two general types of metaphor to explain the embodied changes that occur in the development of high levels of skill, and eventually expertise, in palpation: ‘palpatory library’ or ‘palpatory journey’. The library metaphor implies the value of accumulation of experience in developing expertise. A similar metaphor used was ‘building up a map’. One student said that ‘We try to feel as many different bodies as possible to get a picture of the extremes.’ He gave the example, ‘My mate Dave’s tissue had got all tough through years of manual work, but my friend’s daughter, Katy, is a 14-year-old swimmer and her tissues were so different, the best I’ve ever felt.’ The ‘library’ concept can perhaps be most clearly linked to the concept of habitus, being the result of every experience of palpation. Each touch is both shaped by all previous ones and shapes all future ones. However, the ‘journey’ concept incorporates the idea that the development of expertise and an individual style is not a process simply located within the College, spatially or temporally, but one that continued throughout the career of an osteopath, and indeed, in some ways, started before the decision to train. Additionally, the journey concept is useful to express the way that this process is not linear but takes twists and turns along the way. For instance, one tutor, drawing on the journey metaphor, explained that he used to do a lot of HVT (high-velocity thrust) work, but now concentrates on cranial techniques: ‘Now I can’t imagine how I didn’t find HVT intrusive and aggressive, but I suppose I must have been helping my patients in some way. I now feel like I’ve taken a different path, and I can’t see myself going back to that way of practising’.

The final component in this triangulation method of listening to body-talk is *observation*, and at the College this generally seemed to be associated with developing expertise in practice. In one particular tutorial, the tutor asserted to the students, ‘The art of observation is key in osteopathy... to observe is to become aware through careful attention, for at least a few minutes.’ He warned against ‘restless hand syndrome – trying to get your big paws on the patient’ too quickly. He then proceeded to give the students a huge amount of detail about the kind of things that they could ‘look for’, ‘consider’, and ‘feel for’. The rationale and justification for this was that it would help the students in ‘building up intuitive skills, that is your ability to *see* health as well as *seeing with your hands*’. It is possible to see here the tutors’ implicit acknowledgement of the priority that is assigned to palpation and adjustment within the College of Osteopathy’s teaching curriculum (‘getting your big paws on the patient’). However, observation is also covered earlier in Communication Skills through a class on ‘Patient Appearance’. The worksheet reads, ‘Take care not to allow your impression to become assumptions without challenging them.’ A list of observations are suggested along with comments: (i) *age* (‘Acknowledge your subconscious guess. Are they wearing well or badly?’), (ii) *complexion* (‘Clear, fresh ruddy, pasty? Are they fresh and rested or tired and exhausted?’), (iii) *weight* (‘Make a habit of trying to guess your patient’s weight. Are they fat and lifeless or fat and vigorous? Lean and fit or lean and wasted?’), (iv) *self-esteem* (‘Do they like themselves? How might this show?’), (v) *quality of movement* (‘Can you tell where the problem is? Do these observations contrast with their spoken story?’), (vi) *physiological state* (‘How severe is the problem? Any signs of shock – e.g. pallor, sweating? Are they nervous? If so, why, and can you defuse that?’), (vii) *smell* (‘This can give strong clues about tobacco and alcohol usage. It might also indicate catabolic

state and exhaustion'), (viii) *wealth* ('Are they rich enough for your planned course of treatment?'). A number of these suggestions give the student-practitioner a chance to compare and contrast the information that they get from the oral case-taking, their palpation and their observations, and prepare them for developing plans for case management.

The three ways of listening to body-talk that the student osteopaths learn demonstrate the centrality of embodied interaction in the investigative stage of the healing process. Both patient and practitioner embodiment is an explicit subject of study and attention, as the students learn how to listen to the sick person – through his or her spoken words (case-taking), physical state (palpation) and bio-psycho-social expression (observation).

Homeopathy

The homeopathic student also learns three ways to listen to and communicate with the body-talk of the patient: *oral case-taking*, *observation* and '*energy work*'. I argue below that the concept of 'energetic touch' may be a useful way to explore the latter technique and compare it with the 'palpatory touch' of the osteopaths. However, the boundaries between these three processes are much less clearly differentiated in comparison to the clear triangulation of methods used by the osteopaths. A homeopathic consultation is primarily 'talk', but the student homeopaths learn that throughout the consultation they should not only be listening to what the patient has to say, but also making close observations about the patient's physical body, the 'way' the words are conveyed and 'working with energy'.

The aim of homeopathic treatment is to find a remedy that most closely matches the patient's mental, emotional and physical state (the principle of 'like cures like'). In order to do this, the practitioner must build up a detailed, multi-dimensional picture of the patient, including his or her character, likes and dislikes, susceptibilities, and aspects of the physical, mental and emotional symptoms, including concomitant symptoms, *location*, *aetiology*, *modalities* and *sensations* (the CLAMS method). Even for emotional symptoms it will be important to ascertain these details, such as where in the body the person feels the emotion. For example, a patient may feel anxiety in their stomach, their throat, or their legs, and this will affect the prescription.

Much of the consultation involves the practitioner eliciting 'talk' from their patients about their physical, mental and emotional condition, largely in narrative form. *Oral case-taking* is a skill that the students work on throughout their training. A number of tutors explained that students should think about consultations as 'receiving a case' rather than 'taking a case', allowing the patient to tell his or her story as much as possible without interruption and recording the patient 'own words'. The rationale for this is based on the belief that the body *expresses* its needs very precisely through symptoms, as these examples of tutors' comments from various classes show:

The body is intelligent.

We have forgotten how to listen to our bodies.

The body is not stupid, it tells you what it needs and says 'LISTEN!'. If you don't, next time it says it louder.

From our point of view, the body is *saying* 'Breast Cancer'.

You have to think differently [to be a homeopath], to not make assumptions... How do we know whether a disease is hereditary or if the members of the family have all learnt to manage their emotions in the same way?

I always think: What is the body telling me about the self and where I need to do work?

The kind of 'body' that the students at the College of Homeopathy are working with is not a 'plastic body' that can be moulded at will by advances in bio-medical science (e.g. Williams & Bendelow, 1998: 80). For the homeopaths this control over the human body is an illusion, as there is a much more fluid and interactional relationship between the body, the emotions, the mind and the social and physical environment. The body in the homeopathic model is in a very real sense an actor in the process that can communicate its needs (body-talk). Scott argues that in homeopathy the body can be understood as a 'natural symbol' which challenges a modernist metaphysics:

The biological body is characterized by mobility, intelligence and the capacity for transformation... If a deeper level of consciousness is operating intelligently through such bodily expression as physical symptoms, emotional reactions and the dream life, the biological body must be, at least to some extent, a symbolic creation of that consciousness. It may be understood as a *natural symbol*, creating itself in a form of consciousness which cannot be contained within the conventional codes of language and social practice (Scott, 1997: 112-113).

Using this framework, symptoms, behaviours and emotions are a form of body-talk, they are expressions of a state of dis-ease. Rather than disease being a purely negative aspect of life, or a 'disruption' (Bury, 1982), homeopaths view illness as a potentially positive force for change, perhaps highlighting aspects of a person's life that were unsustainable or indicating, from a spiritual perspective, that the personality may have taken a path that deviates from the 'soul journey'. As one tutor explained, 'The body is an ally to the soul, not the personality.'

The aim of homeopathic case-taking is to get as clear and precise a picture as possible of the patient's health state and potential connections between symptoms. One tutor said, 'A great skill to acquire as a case-taker is to pursue symptoms. You have to get to the root of them or you end up too general.' Another explained that homeopaths have different ways of framing experience:

With asthma, what do homeopaths do? They look at the different asthma situations – [such as] dry asthma or wet asthma. It can be useful to think about aetiology. When the asthma came on after an incident, this can be useful. For example, 'When my mother died', you could give Ignatia 10M. This sort of thing is not in the physical, but is still hanging around in the ether. Or if the asthma came on after vaccination, there are various different remedies, such as Thuja if it is wet asthma, or Silica, or Thymus Gland. Thymus Gland is a bog standard remedy for when the immune system is weakened.

Another tutor gave an example of why it can be really important to ask the right questions.

A patient came to me and she had had weeping ulcers around her right ankle for many years. She had to have regular home visits from a nurse who would redress the ankle. So I thought the right side relates to what has happened to us in a practical sense in our life. And the

ankles relate to support. So I asked her, 'How much support do you have in your life?' She broke down into tears for 5 or 6 minutes. All I could do at this point was to hug her and wait for her to finish crying. Then when she stopped crying I asked her, 'And how do you feel about that?' and then the anger started to come though. So I gave her a remedy not for ankles or ulcers but for suppressed anger.

However, the students are not encouraged to pursue these connections at all costs. As one tutor said, 'People can be deeply resistant to seeing connections, which can be frustrating, but you have to give people the benefit of the doubt and you have to be self-critical. Try not to read things into a case because it has a connection for you.' Being reflective, then, is also a crucial skill in oral case-taking, because the practitioner must respond to the patient's own narrative or the treatment will be ineffective. As one tutor explained, 'You must respond to where the patient is now or you will miss the similar remedy.'

Students are taught that during case-taking, as well as listening to the spoken words of the patient, the practitioner must use his or her skills of *observation*. The 'way' that the patient conveys his or her illness story, gives more insight into the character and condition of the patient. Additionally, much of the value of observation (as ethnographers know) comes not from recording what actually happens, but from what doesn't happen, or from what remains unsaid. The student homeopaths are taught to consider things such as the order of presentation of facts or experiences, or the tone of the voice, or the embarrassment, bravado or emotion behind comments made. This can only be gleaned by the practitioner from careful observation, and various classroom exercises provide an opportunity for students to practise these skills of interaction, to be able to observe what is happening in between the words.

Attention to observation during the therapeutic encounter gives more information for

the practitioner to prescribe with. Thus, the ‘Thuja’ patient might not finish sentences, change the subject, or answer the wrong question (first year lecture on the remedy), while a ‘Staphysagria’ patient may be ‘shy and a little embarrassed but straightforward’ about answering questions about sex (Bailey, 1996).

Finally, and with implications for the two previous aspects of case-taking, students are taught that they are performing ‘*energy work*’, and that an important part of the consultation is to acknowledge and encourage the patient’s expression of energy. This is because the homeopathic healing process involves ‘unblocking’ and ‘energizing’ the vital force and restoring flow and energy to stimulate the body’s own self-healing mechanisms. The student homeopaths learn two interrelated skills to facilitate this, which are often referred to as ‘holding the space’ and ‘witnessing’. To learn these skills, a huge emphasis is placed on the reflexive embodiment of the practitioner, as well as understanding why the skills are important for the patient’s healing process.

The homeopathic consultation is a unique form of interpersonal interaction. A tutor explained, ‘So often in our practice we have people who come in and tell us things that they have never told anyone before, and you have to hold the space for them to do that.’ ‘Holding the space’ is seen to be vital in the homeopathic healing process, because it both gives the patient the opportunity to increase their awareness or consciousness of their situation, and potentially to see connections between symptoms and aspects of their life that they may not have noticed before. In addition, the practitioner should be able to create a ‘safe space’ for the patient to be able to express emotions that may be ‘suppressed’ or ‘blocked’ and may be responsible the distress or illness they are suffering from. The students learn that it is vital to be a ‘witness’ to these experiences that the patient may have. This listening or witnessing

of the patient's body-talk is considered in itself to be a key aspect of the healing process at the College of Homeopathy, because, as one tutor put it, 'If you are doing this, patients will feel that they are being validated, that their experiences are valid... and often at the doctor's they won't be listened to.'

'Holding the space' is a recurring theme in class discussions, especially those in Personal Practitioner Skills classes. The language is interesting, as 'holding' implies a physicality to it, yet 'space' is something that can not really be grasped. There is a physicality to the experience of being with someone and sharing the space of the consultation room, and being witness to their emotions, even without physical contact in the conventional sense. I think, therefore, that it may be conceptually useful to think of this tool for case-taking as energetic touch, not only because it incorporates this ambiguity between holding and space, but because it is useful to compare with the palpatory touch of the osteopaths, which can also be incredibly supportive and caring for the patient. Concepts such as 'caring' or 'emotion work' do not capture all that is going on in the interaction between patient and homeopath.

In order to learn these interactive skills of energetic touch, classes often involve practical exercises where students 'work with energy'. These include Chi Kung, where students do movements that are believed to stimulate and direct the flow of *chi* (energy) around the body and the surrounding environment (because *chi* is not simply an influence on the physical body). Other techniques for exploring energy are shamanic journeying, or meditations. These experiences are included in the curriculum to 'attune' students to working with patients on an 'energetic level'. For instance, during the third year, each college weekend the students cover a chakra and do a meditation to explore the influence of that chakra in their own lives. As with any

form of learning, skill, understanding and confidence working at this energetic level is acquired over time and with practice.

The other main way in which students learn skills in energetic touch is repeated practice in class. However, the tutors do not use conventional 'role-play' or acting as a teaching technique; students explore their own experiences in classroom exercises, or the tutor will take a 'live case' from one of the students. There are two explanations for this. The first is that the various aspects of case-taking are interrelated and unpredictable; something often 'happens' in the consultation, such as an unexpected emotional response, which can not be repeated or acted. For example, one of the methods for 'witnessing' that students are encouraged to 're-member' is the 'honouring of tears'. Students are told that if patients start to cry, which is common, then it is usually best to let them cry rather than trying to stop them, reassure them, or offer them tissues, because they may need to get the grief, frustration, or sadness out of their system. One tutor said, 'Tears are just energy in motion, *e-motion*, and movement is always better than stagnation or suppression.' Students are often given the opportunity to practise honouring others' tears as they are not uncommon in class exercises, such as meditations or PPS classes.

The second explanation is that by working on their own issues and experiences in the educational environment, students learn to develop a state of reflexive embodiment. The idea is that through experiencing the embodied effects of working on, for example, different chakras, students will be in a better position to recognise dis-ease in these areas in others, and to be able to distinguish between what is 'your stuff' and 'their stuff'. As one tutor put it, 'If you haven't done it yourself, how will you hold the space for someone else?' Witnessing and exploring other students' different experiences during these exercises, allows each student to stand

back from his or her own experience, compare it with that of others, and objectify and be reflective about it (cf. Crossley, 2001: 142). Clearly, the students' own bodies are a fundamental object of study in the homeopathic training.

Learning to listen to body-talk in a homeopathic way, therefore, requires the cultivation of skills in listening, observation and energy work/energetic touch, which together are described as 'witnessing' or 'holding the space' for patients. The purpose of these activities is three-fold: to allow the patient to develop a deeper awareness of his or her own body and potential connections between symptoms, which is one aim of the healing process; for the practitioner to understand the nature of these connections and to be able to 'get to the root of the problem' in order to be able to treat appropriately, and, finally, the expression of emotions can have a healing effect in itself. In this model of investigating the body in illness, the body-self appears as a communicating *agent* (a talker) in the healing process, rather than just a text to be 'read' by the practitioner (see Daniels, 1986 for a discussion of the patient as text). The homeopathic body-self is an agent both in the sense of spoken communication and as a creator of bodily 'symptoms'. The students' ability to understand 'body-talk' is, therefore, a key goal in their learning. Indeed, being able to listen mindfully to 'body-talk' is in itself a vital aspect of the healing process.

Learning to listen to body-talk is a useful way to think about the different practical methods that students learn to take cases in order to collect the relevant information that they need about the embodied patient. This is because body-talk as a concept expresses the idea that the embodied patient is not a passive recipient of health care, but that the 'body' is able to communicate its distress and its needs. Students have to learn to effectively listen to and interact with that 'body-talk', and to do so they must

use all their embodied faculties in a flexible way. Repetition and development of these skills in the learning environment causes them to become ‘habit’ thereby changing the students’ own state of embodiment, particularly in relation to other people.

Body-stories: learning to evaluate cases

Student practitioners must then learn what to do with the information that they have gathered through listening to the body-talk of the patient. These skills of evaluation and analysis can be usefully thought of as developing narratives or ‘body-stories’ to explain how the patient has arrived at their state of dis-ease. Some of this analysis involves the practitioner simply ensuring that s/he understands the order in which various events have occurred to see if there are connections, for instance, by the construction of ‘time-lines’. Interestingly, investigation (of body-talk), analysis and treatment are rarely distinct chronological phases in the osteopathic and homeopathic healing process, but significantly overlap.

Understanding how student practitioners learn to construct body-stories with/for their patients, and justify their treatment plan, gives further insights into the embodied nature of the therapeutic relationship, and how students deal with learning about the uncertainty inherent in the healing process. In addition, it is possible to explore the extent to which body-talk must be ‘translated’ in order to make it useful to the practitioner in the healing process. In order to explore these issues, I will look at how students learn the ‘theory’ about analysing cases, in classroom encounters (encounters with real patients, and presenting cases for assessment will be considered in the next chapter). It is possible to see that narrative is a key tool in the learning

environment, both as a practical tool that students learn for the analysis of cases, and the treatment of patients, and as a teaching tool to illustrate the healing process.

Osteopathic body-stories

The goal of osteopathy is, according to a lecturer in Structure Function, ‘the regaining of the normal equilibrium of form and function that typifies good health’. The students are taught that in order to see how best to treat a patient and manage a case (e.g. frequency of appointment etc.), they must understand how the patient came to arrive at this point of embodied distress. This may seem self-evident, but what is perhaps more distinctive is the depth of analysis of the ‘body-story’ of the patient that has lead up to the present condition. As one tutor suggested,

My experience suggests that osteopaths often have more time to work out more complicated patterns of aetiology [than medical doctors]. When talking to students I just say I am ‘making up a story that makes sense to me and the patient at the time’. I do not say that doctors can not do this, or that osteopaths always do a better job. I think we more often set out with it in mind.

In particular, osteopaths often use the concept of ‘legacy’ or ‘tissue memory’ as an explanatory mechanism.

Legacy is understood to be the effects of the totality of people’s experiences and students are often encouraged to make a time-line of significant events in a person’s life as a starting point for their analysis. In a SF lecture on ‘Adulthood and Old Age’, the lecturer explains the benefits of using a ‘time-line’ to analyse cases. There are ‘accumulating factors that hinder healing’ so ‘the story that the patient

tells, leads to the aetiological basis of osteopathic medicine'. It is important, he continues 'to understand how the patient's body has got to the point that it is predisposed to certain injuries or malfunction. Legacies are not just physical, but bio-psycho-social'. Later in the lecture he focuses specifically on the physical body, or 'tissue memory following tissue injury', which is, he says 'a legacy that needs to be understood when applying the osteopathic hand'. He characterizes tissue memory under the following headings: 'A, physical changes to the structure of tissue; B, neuro-endocrine 'fortification' of the tissue related to a segment(s); and C, psycho-emotional maintained reinforcement of pain and posturing for pain'. He stresses that it is essential to understand legacy in order to treat someone osteopathically.

While the psycho-social aspects of the legacy are seen to be important to the osteopath, at the college much more time is spent on teaching about the impact of physical events, such as injury. Discussions about emotional responses are often included but only at a basic level. For instance, a lecturer talking about 'soft tissue' whiplash explains to the students, 'At two years plus, those who still have symptoms dislike (a) that they can not do what they did before, (b) that they are still suffering, (c) that no one helps them, and (d) that treatment does not work'. The lecturer goes on to ask, 'What can we learn from this? What can osteopathy offer in the right hands?' It is presented to the students that as good osteopaths (with the 'right hands') they need to develop strategies for dealing with psycho-social aspects of illness as well as physical problems. However, the presentation of the emotional response that the patient would have to his or her situation makes assumptions about this response, rather than urging students to explore, or at least confirm, individual responses.

The quote above suggests that ideally, the body-story developed in the consultation should 'make sense' to both the patient and the osteopath, thereby

allowing the patient an active role in the analysis process. However, this is limited by the ‘translation’ that the practitioners perform on the patients’ body-talk, in order to understand what has happened to the structure and function of the patient’s body as a result of the legacy. For instance, one tutor said, ‘Practising osteopathy involves changing subjective words into objective physical meanings. This translation is the foundation of the practice... You *evolve* from your emotion to your objective’ (my emphasis). This comment was made apparently without a reflective appreciation of the extent to which this dualism gives priority to the osteopath’s perspective. The extreme language of this example was not necessarily representative of all the tutors, however, it is clear that the anatomical and diagnostic languages used by the osteopaths would not be accessible to most patients. Therefore, translation would potentially need to occur twice in a consultation: from the patient’s symptoms (body-talk) to the osteopathic understanding, and then back into non-technical language so that the osteopath can communicate (some aspects of) the body-story that s/he is working with. It may be that a hierarchy of value about different ways of seeing is difficult to escape in health care, where the practitioner has been trained for years to understand and analyse the body, and indeed, this ‘expertise’ is often what a patient (voluntarily¹²) chooses to seek. What is perhaps the key issue is what happens if the patient and the practitioner’s body-story constructions are not commensurate. Certainly, the data above suggests there is a potential for this to happen, and so it can not be claimed that the construction of a body-story is presented to students as an entirely joint endeavour. Certainly, in the set-up of the student clinic, much of the discussion and analysis of the case is done without the patient being present, but this issue will be explored more fully in Chapter Six.

¹² Most osteopaths work in private practice, and so are reliant on the continued satisfaction of their patients. Increasingly, however, osteopathy is being offered by referral from General Practitioners.

Students are required in the learning environment, to develop an ability to construct explanations for disease and treatment plans in a step-by-step fashion, drawing on their structural and functional (anatomical) knowledge of the body and the information that they have gleaned from listening to the various forms of body-talk (oral case history, observation, palpation). However, with time the artificiality of that step-by-step approach is exposed. In fact, the process is much less linear, and students learn that listening to body-talk, analysis, and treatment are often intermingled in practice.

Nonetheless, to begin with, many of the classes explore different aspects of the healing process as distinct and linear stages. Working through case studies in class is an integral part of the teaching at the College of Osteopathy, and is usually associated with work on specific parts of the body. For instance, a second year tutorial that followed a lecture on 'the upper limb', explored the case of 'Margaret' who was experiencing pain in her shoulder. Students were required to prepare for the tutorial by revising their knowledge on the anatomy and pathology of the relevant *part of the physical body*. The student were then presented with the case of 'Margaret' in *narrative* form, including personality, living situation, and employment: 'A pleasant but anxious 50-year-old lady, a mother of two adult children... [who] lives with her husband, who was medically retired from work four years ago. They enjoy taking long walks with their dog, she enjoys her garden and has a part-time secretarial job 2-3/7 [two to three days a week] at a local training company which helps supplement their income.' Information about her pain, its aetiology, progression, aggravating movements, and current medication was also given to the students, as well as her reaction to the fall, which was the cause of the current pain: 'At the time of the fall she felt shaken, within a couple of days a bruise developed

over the point of the left shoulder that over the next three days tracked down the front of her left arm to the elbow.’ The students are given medical history information, including that she is ‘post-menopausal, diagnosed as a diabetic four years ago (now diet-controlled), diagnosed as suffering from irritable bowel syndrome three years ago and had her gall bladder removed two years ago.’ Finally, the case study notes that ‘Margaret sits in front of you in obvious discomfort, holding her husband’s hand , she is almost in tears...’ Clearly, the case study covers a range of issues relating to the patient. During the tutorial, students are asked to consider the case in terms of both exploring the nature of the physical *dysfunction*, and social/physical/emotional *legacy* of the symptoms. And they are required to propose a plan for the ‘overall *management*, including osteopathic treatment, of the person’.

This is a useful learning tool as it brings a formal clarity to the healing process, and through repetition it enables students to develop skill and eventually intuitive expertise in dealing with patients. In this way, students learn to develop a body-story that makes sense in terms of osteopathic knowledge. Students learn to consider differential diagnosis, and, in clinic, are not permitted to treat patients until they have developed at least a working diagnosis. The students’ analysis includes an aetiology, a progression towards dysfunction and a current state (body-talk) and from this information a diagnosis is made, and then the student osteopath can choose appropriate treatment.

However, as the students move through the course, they are encouraged to recognize the limits of a linear ‘diagnose then treat’ model. A second year class, taken by students before they start working in the student clinic, is called Osteopathic Diagnosis and Evaluation. This is part of the process for students to develop clinical judgement. The aim of the course is to ‘Encourage students to develop their skills of

osteopathic evaluation and enquiry, while learning strategies to deal with the uncertainty this can evoke'. Students are supposed to develop a 'practical problem-solving approach to the understanding of the patient and their problem(s)... not syndrome recognition'. In this differentiation that the course tutor uses, diagnosis ('syndrome recognition') is local and specific, while evaluation also takes into account the rest of the body and social factors, or as the tutor put it 'what else is going on in that person's life'. He warned, 'You may feel that we [on this course] lose sight of that sometimes.' The tutor's reinforcement of the need for a more holistic way-of-seeing indicates that the emphasis of the course may steer away from this sometimes in favour of the more concrete diagnostic approach. Yet he reminded the students that, 'It is easy to think that classes are important because that is where the learning happens, and to think that the clinic must fit with stuff here, but actually this stuff must fit into the clinic work, not vice versa. The clinic is where it really matters.'

The uncertainty of developing appropriate diagnosis and evaluation is highlighted to the students, although their response is not enthusiastic, so the tutor says, 'Over time and with experience, I have become more comfortable with what I don't know in practice... The problem with human beings is we can't simplify them... If we do we lose bits of them along the way.' He brings up the 'driving test' analogy that students and staff repeatedly draw on at the college: 'Although training here gives you something to say you are competent, it is only through practice that you become a really good osteopath.' Similarly, in a Technique class, the tutor warns students that there are a range of ways of developing body-stories, 'You get given the basics here... by now you must realize that there is not one way of doing things.' At an IMS (Involuntary Motion Studies) technique class, the tutor reinforces the uncertainty of much of the knowledge acquired: '[This class] has raised more

questions than answers, but hey, that is the way it is guys!’ He also points to the limitations of book knowledge in developing skills: ‘The books will tell you [one fact]... what they may not tell you, unless perhaps you dig deeply is [this more complex explanation].’ Responding to a question about how the Involuntary Motion System works and whether, because it is so related to fluids, it may be affected by the moon, one of the tutors respond:

We don’t really know... the best way of viewing it is the interaction of mobility and the flow of CSF [Cerebral Spinal Fluid]... It is fair to say that we, as tutors, and others who teach in this field have bought into this model of fluid fluctuation... Whether it is related to lunar movement – that is just conjecture – you can argue it either way.

To complicate matters further, it is rarely the case that diagnosis/evaluation and treatment are mutually exclusive. For instance, while the healing effects of touch, from a psycho-social perspective, are something more fully explored by the osteopaths in the student clinics, it is worth noting here that palpation can in itself play an important role in the healing process, because it demonstrates care. For instance, one of the tutors described osteopathy as the ‘concretization of love’. Although clearly in theory the students are encouraged to proceed formally through the various processes, as shown above, in practice, as one tutor put it, ‘part of the treatment also forms part of the diagnosis.’ In a fourth year Technique class the tutor explained that he often observed students working with the more simple model of assessing the patient, then applying the treatment techniques that they think are appropriate. He explained that this often means that it is difficult to tell whether something has been effective, and that a much better way was to enter into a ‘dialogue with the tissues, so that you are constantly assessing, then treating, then assessing,

then treating and so on... It is a kind of constructive fiddling!’ This is also vital for evaluating the treatment, he explained, ‘If the patient comes back the next week better it doesn’t mean that your technique worked, loads of things could have happened to that patient in the time that could affect how they are... You must feel the tissues to see if your technique has an effect.’ It is interesting that in this Technique class ‘life’ is not considered to be something that could be directly or indirectly part of the effect of osteopathic treatment. Nonetheless, this idea of ‘dialogue with the tissues’, although largely referring to the physical body level, highlights the extent to which osteopathic treatment happens at the point of interaction between two bodies, rather than being simply imposed on a passive patient body.

The following example, given by the tutor in a Comparative Technique class, shows how narrative can be used as a teaching technique to illustrate the healing process. It also indicates how the process of listening to the body-talk, forming a body-story and treatment are difficult to separate in practice.

‘A woman came to me who had been having bad headaches ever since she was mugged. We tried all sorts of treatments, but then I noticed that here [indicates over the student model above her left shoulder] there was a palpable feeling that she was expecting to be hit again. It was about how she was holding herself. So I held my hand over the area [off the physical body] where she feared being hit again until I felt it dissolve. She never got headaches again’.

The ‘story’ here is framed in a way that makes it very appropriate as a teaching tool.

The tutor indicates that ‘all sorts of treatments’ had not been effective, because the real body-story – including the aetiology and the legacy of that in the tissues – had not been understood fully. When that ‘palpable feeling’ was ‘noticed’ the ‘treatment’ was clear, even though it was not conventionally osteopathic. Value is assigned to this

correct recognition of the body-story and, perhaps obviously, the cessation of the headaches.

The IMS classes that the students undertake are the site for a particularly clear exemplification of the way that evaluation and treatment can be inseparable in osteopathy. The students learn that it is actually by ‘listening’ to the subtle involuntary motion of the body’s fluids and observing how distorted or otherwise the cycles of motion are that healing takes place. The shift from listening to the body-talk, to developing a workable body-story and on to treatment are barely perceptible. Teaching this is very difficult, as the tutors have to find ways of explaining and teaching the subtle movements that they are feeling. The staff-student ratio is very high for this class, about 1:4, so there is one tutor for two pairs of students. The students practise listening to the Involuntary Motion System, by placing their hands usually on the cranium or the sacral area, and the tutors place their hands on another part of the body and talk the student through the technique and the kind of sensations that they are likely to be feeling. The lead tutor for the session explained to me that by ‘feeling what was going on from the other end [of the movement cycle], through experience I’ve learnt to be able to understand what the student would or should be feeling, so this enables me to talk it through if the student is having difficulties.’

The tutor pointed out, ‘There is always the criticism that it is auto-suggestion, and I feel that to some extent that is true, but I think that is an inevitable part of the learning, especially with something so subtle.’ In some ways, this is part of the process of embodied learning in all technique classes; students understand what it is that they are ‘supposed’ to feel and only through that awareness do they develop the sensitivities to feel it themselves. The following quotes illustrate typical interactions

and the kind of verbal support that the IMS tutors give the students, while they are both palpating the ‘patient’:

Can you feel the cycle [of the fluids] going round? Feel another cycle complete then move your hands away;

Tutor: I think that we have reached the still point – can you feel that?’

Student (with excitement): Yes, I really can!

Student (to me afterwards): I’ve never really felt much before [in IMS classes] but I can really feel it now;

Can you feel the resistance and the push of the area? Now just *intend* to stop that, to resist it. [pause]. That is it. Now let it go a bit. [pause]. And put the resistance back on.

In this last quote there was no movement of the student’s hands that was perceptible to the naked eye. The ‘intention’ was a movement in the mind, or something so subtle as to be barely physical.

The student osteopaths’ experiences of learning how to evaluate patients and determine suitable treatments in ‘theory’ demonstrate the extent to which it is vital for them to gain a holistic picture of the aetiology and progression of the problem, in order to evaluate and treat the patient and manage the case as a whole. The construction of the body-story is limited in the extent to which it can be conceived as a ‘joint’ story developed by both practitioner and patient. Although the patient contributes his/her spoken and physical body-talk, a great deal of *translation* takes place, both linguistically and in terms of structural (anatomical) and functional understanding of the body. Nonetheless, these body-stories can not be understood other than as a ‘joint’ endeavour in the sense that the basis of the construction of the

story takes place at the interface between two bodies, in the forms of body-talk (spoken experience, observation and palpation) that require the physical presence and attention of both practitioner and patient.

Homeopathic body-stories

The aim of the homeopathic healing process is to restore vitality to the patient, through the administration of homeopathic remedies which stimulate the body's own vital force, or self-healing mechanisms. The vital force (like *chi* in Chinese Medicine, and *prana* in Ayurvedic Medicine) is not a 'material' substance, but a concept that unites mind, body and spirit, and because of this, tutors at the College of Homeopathy repeatedly remind students that homeopathy is an 'energy medicine' dealing with the vital force, rather than simply the material body. In order to determine the correct remedy, the homeopath must apply the principle of 'likes cures like' and find the remedy that is the most similar to what the patient presents with. For the homeopathy students, developing skills in constructing body-stories has implications not only for the evaluation of the case, but is directly linked to the choice of remedy. Remedies, like people, have their own complete stories, or 'pictures', that incorporate mental, physical, emotional, social and spiritual aspects.

For the students, then, they must develop both skills in identifying the body-story of the patient, and knowledge of the remedies, in order to be able to select a remedy or combination of remedies that best match the 'energy' of the patient. As suggested above, the students are encouraged to let the patient lead the consultation (to 'receive' a case), rather than having a list of topics to cover. Obviously in an hour, or any limited amount of time, the patient can not tell the practitioner everything

about him/herself, and there will inevitably be a focus to the body-talk. Students must, therefore, learn to be comfortable with the *uncertainty* inherent in their case-taking, and *flexible* in their approach to treatment. As remedies have mental, emotional, physical, social and spiritual aspects to them, the ‘match’ can occur at any or all of these levels. For this reason, students at the College of Homeopathy are taught a number of different ‘methodologies’ for case analysis¹³ (Watson, 1999, discusses fifteen homeopathic methodologies). This teaching is not usually in the form of direct classes on Methodology, although these do happen, but is organically knitted into the discussions about remedies, case-taking and health/dis-ease.

Different methodologies include *constitutional* prescribing which focuses the mental and emotional picture of the patient, the dominant ‘physical generals’, and ‘keynotes’ or SRP (Strange, Rare and Peculiar) symptoms. Another approach is to use *aetiological* prescribing; in a class on Aetiology, the tutor explains that as homeopaths the focus should be ‘first and foremost on the presenting condition’, but sometimes,

There is a point from which all this starts from, the never-been-well-since situation, and there is a change of direction of the whole person at this point. The presenting state should still be the focus of your attention – how they have responded to an event – but sometimes the presenting state can be a muddle, but the event is clear. You can respond to what is the *clearest part of their story*. So if the presenting state is not clear, go back to the last point of clarity. The body is looking for a piece of information that it can recognize (my emphasis).

¹³ The College of Homeopathy is not a ‘classical homeopathy’ college. ‘Classical’ homeopaths do not tend to use multiple methodologies in their practices, but generally stick to a (Kentian) mental/emotional dominant picture approach, searching for the patient’s ‘constitutional’ remedy or another remedy that matches the patient’s acute state. Put simply, the classical homeopath tends to use the ‘single remedy’ approach that Hahnemann used. Other colleges, such as the College of Homeopathy, use a ‘practical’ approach, which encourages the use of different methodologies and multiple remedies if appropriate.

Another approach is to prescribe *therapeutically* which is particularly common for acute conditions, and tends to focus on the specific physical or emotional symptoms that are relevant at the time, such as shock or trauma, and is not necessarily reflective of broader issues in their life or their constitutional picture. The choice of methodology is another way in which the students learn to match their response to the patients. For instance, the practitioner may feel that s/he has not got to the 'root cause' of the problem, because there are other agendas or social or environmental dynamics that impact on the case ('maintaining causes'). In this case, s/he may choose a *layers* methodology, working only on the superficial or the physical to begin with, but aiming with time to peel back the layers, 'like an onion', to reach the core of the case.

The discussion of cases in the classroom is very often within remedy lectures, which tends to reproduce 'ideal' cases. Narrative then is used as a teaching tool to illustrate the remedies, often to help students get a feel for the 'energy' or 'essence' of a remedy. The meaning of 'essence' tends to lie somewhere in the emotional/social realm, and cannot easily be grasped by language. It may be an 'atmosphere' in the room, such as the case of the Staphysagria class, mentioned in the previous chapter, where a student talked of her experiences of miscarriage. In addition, tutors often present case studies or refer to historical or fictional characters, and by doing so locate the remedy learning in an embodied and socially located figure. For instance, the same remedy, Staphysagria, was presented by a different tutor as similar (from 'like cures like' or '*Similia Similibus Curantur*') to the character and story of Mahatma Gandhi. Students are encouraged to follow up remedy lectures with their own reading, writing in their learning journal, and possibly taking or administering the remedy to gain a deeper 'embodied' understanding. One tutor's advice was:

There are three ways to learn, LISTEN, UNDERSTAND, and PRACTISE. You can listen in lectures and take notes, or you can try to come to an understanding about the remedy. From there you can go on to practise it and gain more experience and deeper understanding... It is very important what my relationship is to a remedy, not just what the lecturer has told me.

In order that students are able to recognize the similarity of remedies to patient's body-stories, they must 'get a feel' for the remedy or, as mentioned in the previous chapter, 'be[...] with the energy [of the remedy] and start embodying it and so knowing it'.

The distinctiveness of the homeopathic approach is to respond to 'body-stories' with homeopathic remedies, each of which describes one of the many possible connections between social experiences (such as oppression, abuse, lack of confidence), emotional or mental states (grief, anger, confusion) and actual specific impacts on physical health in the form of pathology (asthma, Irritable Bowel Syndrome, headache). Homeopaths have a huge number (over two thousand and growing, of which about thirty are 'polycrests' or major remedies) of stories to explain the possible ways of being-in-the-world – these are the different 'remedies' and these contain multi-layered descriptions of different ways of being, such as aetiologies, personality traits, appearance, physical symptoms and emotional experiences. Homeopaths often use the term 'remedy picture', but I feel that in the context of this discussion it may be more useful to think about 'remedy stories' as it explicitly encompasses the temporal aspect of the remedies. Students are taught remedies and encouraged to move away from the static concept of labelling disease to a dynamic understanding of patient's stories. 'We are interested in processes' one tutor explained, rather than 'diagnosis' and 'labels'.

To illustrate how students are taught about ‘processes’ in remedies, edited excerpts from two remedy lectures are presented below, both addressing people who have become worn down and exhausted. The first remedy is Arsenicum Album and the second Calcarea Carbonica. Compared to the tendency at the College of Osteopathy to assume emotional responses to certain problems, the focus on understanding the individual response to a situation, or the individual build-up of a state (such as exhaustion) is clear.

Arsenicums need to be in control. This helps them to allay fears. Their fears are particularly around health and they fear death to their very core. So they carefully plan their day, make lists, are neat and tidy so that they know where things are. They are fastidious, perfectionists, and very driven. As the Arsenicum picture *goes deeper* the fear *extends* to worrying about their family being ‘got’ as well. So the Arsenicum starts with fear, so they turn to perfectionism to control it, but this takes a lot of energy so if they begin to not have enough energy they can become compulsive, so get OCD [Obsessive Compulsive Disorder]. *Then* they get more fears about being invaded, *which turns* into a deep depression, and *eventually* to suicidal impulses. *At this point* they may turn to knives for self-harm, and they fear committing suicide and fear hurting others or killing others. *When they reach deep pathology* they start to crumble at all levels and maybe become a recluse. Also they can become anorexic *at this point*, because of their fear of food (*my emphases*).

Calc Carb like structure, routine, family, order on the outside. Calc Carb children learn slowly and they need to do it to be able to understand it. They are earthy and practical. They are steady and like to work at a slow pace. If you want to know how to do something, ask a Calc Carb who will be able to explain it clearly step-by-step. They always have lists of things ‘To Do’. *The problem comes* when the list gets too long and they have to speed up. They have difficulty saying ‘No’ to people as Calc Carb wants to help everyone. Like water it spreads out and its boundaries get wider, and *eventually* becomes too thinly spread which leads to disease. This overwork *leads to* disease. They get high level anxiety rushing about

doing everything, because they lose the ability to discriminate what is important. They need to do the job well, but they are not fastidious like an Arsenicum. They like the physicality of work and desire physical activity. They do perspire a lot especially on the forehead and hands. They are prone to heart attacks due to anxiety, and despite activity are prone to putting on weight. They do handle their weight well though. You often see that chubby children are Calc Carb (*my emphases*).

The assessment of the patient then, is not ‘OCD’, for example, or even ‘worn-down and exhausted’, but ‘has become worn-down and exhausted in an Arsenicum-like process’. In addition, the *character* in the story is the remedy, which contrasts with the biomedical tendency to refer to patients by their disease (Stacey, 1997). The implications of categorizing patients by remedies, rather than disease labels, means that there is an intermingling of the physical and emotional patterns as part of a process, or story, rather than as a snapshot. However, there seems to be some potential for these remedies to be a kind of social stereotyping, in terms of class or gender for example. For instance, some remedies are primarily illustrated and used for women, such as Sepia (often characterized as the ‘worn-down housewife’) or Apis Mellifica (‘the mother-in-law’). One of the tutors warned the students against thinking of remedies as ‘stereotypes’, but suggested that they think of them as ‘archetypes’, or ideal-type examples, so as not to miss the different stages of dis-ease at which a patient could present to the practitioner. This means that students have to be familiar with each remedy at many levels: at different ‘stages’ of pathology, and at the physical, emotional, mental and spiritual level.

However, homeopathic practitioners do not need to know every symptom of each remedy picture by heart, as they have reference books – the Repertory and Materia Medica – which contain all of the detail. The repertory is a homeopathic

reference book that contains lists of symptoms or states known as ‘rubrics’, which are usually arranged alphabetically. Following each rubric is a list of remedies that are indicated for it. Homeopaths can then look up the symptoms in the repertory and calculate which remedy is ‘most similar’ to the symptom-picture of the patient. The repertory language is very unique, and it takes students a long time (maybe even a whole career) to become familiar with the whole repertory. The following is a selected sample of rubrics from the Repertory that is recommended by the College of Homeopathy:

Abdomen. ALIVE, sensation, of something, in

Generals. SHOOTING, pain

Head. PULSATING, sensation, temples

Mind. DEJECTED, feeling

Mind. LATE, always, too

Pregnancy. CONSTIPATION, during

Skin. CALLOUSES, skin

Sleep. NARCOLEPSY, overpowering sleepiness

Toxicity. MUSHROOMS, poisoning, ailments from

Vision. FIRE, a sea of, on closing the eyes

(Murphy, 2005)

When using the repertory there is, therefore, a degree of *translation* of the patient’s words into rubrics. Homeopaths do also, to some extent, use medical terminology for diseases to assist in this repertorization process, such as Narcolepsy in the above example. However, the process of choosing a remedy always ends with the use of a Materia Medica which provides a detailed overview of the remedy returning it again to its ‘story’ form.

There is, of course, also some element of ‘translation’ of experience in the spoken words of the patient because bodies never talk ‘in the raw’ but words are mediated by the social context (see Chapter Six for a more detailed analysis of the ‘production’ of the ‘patient who talks’). In addition, the homeopath selects ‘relevant’ information from what the patient says to record in his or her notes. While clearly there is not the same rigidity in the content and depth of information that must be collected (as there is at the College of Osteopathy), there are still ways in which the homeopath influences what is said (as with any form of unstructured interviewing). The homeopath inevitably carries with him or her assumptions about the kinds of stories and connections that can exist, and has aims and objectives for the consultation (to develop a working body-story and find a similar remedy).

After a remedy is chosen and administered, healing is evaluated at all levels, and the student homeopaths are taught that as well as improvements in symptoms, encouraging ‘awareness’ in the patient is also a key aim of the treatment. This relates to beliefs about the healing process. Healing or ‘transformation’ is believed to occur when the vital force is allowed to function unhindered by physical or emotional blocks, such as suppression or lack of energy. These examples of tutors’ words in various classes illustrate this:

Healing is about become conscious of why we are ill, and making the changes... so in this sense remedies don’t matter... plenty of people are healing themselves without remedies, so why would we be so arrogant to assume our remedies are essential. Remedies are little bundles of awareness, little parachutes; they can aid the process.

The healing moment for her was her acknowledgement [of her reasons for her fatigue and lack of inspiration] and the remedy supported that.

That is basically what you are doing here, training to be homeopaths so you can help people to transform.

The following edited case study given by a tutor illustrates aspects of the way healing is perceived to be a process, incorporating physical and emotional aspects of the person's life:

A woman, 47, with recurrent sinusitis, thrush and asthma... very heavy use of orthodox drugs to control asthma... The prescription, just heart support, lung support and Carcinosin 200 was given and it was quite transformative for her. The next time, I upped the Carcinosin to 1M on day one, then as the picture was emerging by then of a constitutional remedy Calc Carb – I gave a 1M on day two, with the daily remedy support combination continued. The next time, the woman had had a really good talk with her aunt about the family and a lot of stuff was coming off her chest. She was also reducing the frequency and the intensity of the puffs she took.

The analysis and treatment of the patient are in a way conflated at the point of recognizing the 'similar' remedy. At one level, students are encouraged to construct body-stories to explain the disease process, to interpret the body-talk of the patient ('the body is intelligent'). Yet the use of a repertory, notwithstanding any translation in this activity or the selection of symptoms to look up, seems to indicate that homeopaths use the information given to them by patients about their emotional state and mental and physical symptoms at face value as empirical data. What is clear is that interpreting illness, or indeed arriving at the 'correct' body-story and associated similar remedy is not a simple process nor an unproblematic one. It is perhaps in the interpretation of the healing process, that the biggest potential for disjunction between patient and practitioner lies. The viewpoint of the body as intelligent and the concept

of the ‘vital force’ is not necessarily one that all patients share, certainly not ones who adopt a mechanical or biomedical model of the body, and therefore there may be some negotiation between patient and practitioner of the appropriate body-story. Students are taught that they may need to do some work on ‘educating’ the patient about the homeopathic healing process. Whether, and how, this happens in practice will be addressed in the next chapter. Additionally, there is a wider debate within homeopathy about which symptoms are the most important and students are exposed in class to many different perspectives on that, such as:

If you can find an aetiology in a case, you’ve cracked it.

My big thing is miasms. I always think about the active miasm of the patient.

Always look for the general physicals and the emotionals, so that you understand what the person’s constitutional remedy is. You can do so much just with the one remedy over many months.

The students learn that there is no single, right way of practising homeopathy. For this reason, students are encouraged to file their notes in their learning journal in a way that makes sense to them. This then becomes a basis for ongoing learning throughout the career.

As well as flexibility in case-taking, analysis and treatment, the students must also develop their *reflexive* skills. The theory behind homeopathic treatment suggests that if reflexivity fails and the homeopath imposes his or her own interpretation on the patient, then the ‘match’ will not be accurate and nothing will happen, and so treatment will be ineffective (‘The body is looking for a piece of information that it

can recognize.’). Students learn a variety of possible ways of connecting different physical, mental and emotional symptoms, but they are warned that that they must listen to the ‘language’ of the body: ‘We have to look at what is there, not make assumptions.’ A quotation from one of the core books at the College of Homeopathy illustrates this belief:

The wise homeopath does not pretend to know what causes a person’s suffering, nor does she comprehend the mystery that lies behind all healing.

When an event occurs which creates suffering, the homeopath remains mindful that every cause is the effect of another cause. Does the trauma produce the illness, or does the state of suffering attract trauma to itself? By not knowing the answer, she stays open to all possibilities. By refusing to think in linear terms, she is able to glimpse the invisible threads that tie all phenomena together.

The homeopath’s task is simply to make association, noticing how one thing relates to another. Gradually, she begins to understand that every single thing is connected to everything else in the universe (Watson, 2004: 40).

Finally, the students are taught to be critical about their own reflexive capabilities. One tutor explained that they are supposed to embody ‘detachment with compassion... hold up a mirror [to the patient], do not take it [their stuff] on’. She warned, ‘If you can’t be a mirror, [it] may be best to refer the person on. Be honest about who you are.’ In this way students’ own bodies and personal biographies are fully implicated in the learning environment. They are repeatedly and consistently challenged to address and understand their own experiences, so that they can be reflective about them and develop a state of reflexive embodiment for the future.

Body-stories are a useful concept to think about the ‘theory’ behind the healing process in osteopathic and homeopathic medicine. Narrative is both a useful analytical tool to explain the progression of disease and manifestation of body-talk and a useful teaching tool to illustrate the healing process, and justify treatment. Indeed, for the homeopaths, the theoretical gaps between recognizing a dominant body-story in the patient, selecting the similar remedy and treatment are very small. The linearity of simple cause and effect or diagnosis and treatment are destabilized by the potential complexity of the narrative structure, which can recognize connections between physical, mental, emotional and even spiritual symptoms, and social and environmental conditions in the individual biography or ‘story’. Body-stories are, in both practices, co-produced through the embodied interaction between patient and practitioner. The power relations of this interaction will be explored in the next chapter.

Changes in student embodiment

We have seen that the bodies of the students are deeply implicated in both the learning environment and the healing process, but it is worth considering more specifically the types and extent of embodied changes that occur and what may limit them. Students develop new ways-of-seeing or listening to and interacting with others, which are integral to their professional identity and role, but may also ‘spill over’ into other non-professional areas of their lives¹⁴. However, training also has implications for the students’ own health and their experience of being-in-a-body.

¹⁴ The evidence of this ‘spill over’ comes largely from students’ reported experience, as only a small proportion of my observations took place outside of the college environment.

The work that students do familiarizing themselves with the function of the human body, the types of health problems people have and the ways of treating them, mean that they learn new ways of seeing or listening to the body. For instance, both the homeopaths and the osteopaths learn to see the potential connections between emotional expressions, physical and mental symptoms and characteristics of the pain or discomfort (such as situation, radiation, character, relieving and aggravating factors). Crucially, in order to understand the embodied effect of learning for the students, we must recognize that these newly acquired ways of listening to and interacting with others is not something that can be switched on and off at will.

Homeopathic students do not only recognize remedy pictures in patients, but in friends, family members and themselves. At one level this is vital to the learning process, as it serves to deepen the understanding that they have about the remedy, increase their familiarity with the remedy, and develop their practical knowledge and intuition. We can even say that seeing health and illness as ‘stories’ becomes part of their embodied way-of-being. The learning experience, therefore, has a profound impact on the students’ personal approach to health, and in many cases that of their families. The development of skills in ‘holding the space’ and ‘witnessing’ changes the student practitioner’s sensitivities and understanding of the importance of carefully listening to other people. In one class about flower essences, the tutor said, ‘If you go into this flower essence energy, you can’t help but change your perceptions about things, change yourself and the way you relate to others.’ Students are encouraged to record their own experiences of treatment and their personal responses to remedies in their Learning Journal in order to cultivate this embodied understanding of the practice of homeopathy and the effect of the remedies.

The osteopathic students reported that they cannot ‘switch off’ their palpatory skills. A student said, ‘You are going to give someone a hug or something and you end up feeling their spine!’ I observed that osteopathic students and tutors are also highly tactile; students and tutors alike, if trying to explain something to me or to each other, would hold the relevant part of the body and *show* rather than tell it. It is virtually impossible to explain effectively certain aspects of osteopathic knowledge without physical touch. The fact that students quickly become comfortable with taking their clothes off in classes, as most techniques must be practised directly onto the skin, also illustrates changing embodied ways of being. As one student said, ‘You lose all your inhibitions doing this course, ’cos you have to take your clothes off in front of each other every day.’ The physical intimacy of the classes carries the potential of challenging issues around the body and sexuality, but the risk of this was very much hidden or taboo at the College. Interestingly, it was only at a social event some months after the official research had ended, that a female student said to me: ‘We are all happy taking our clothes off in front of *each other*... some of the tutors are a bit pervy though.’ Questioned further she said, ‘Sometimes if you are struggling to do a technique they come up right close behind you and put their arms around yours to show you. Sometimes it is necessary [for them to do it] but not always.’ Nevertheless, the students’ awareness of the body, and the implications of bodily interactions, are heightened during the course. The effect of training in Technique on the body-self of the students goes beyond the acquisition of new embodied skills to an appreciation for what the experience of treatment could be like for an osteopathic patient.

The students’ own health is also affected both positively and negatively by doing the course. For the osteopaths, at one level practising techniques on each other

can be a positive experience, seen in feedback such as, ‘Yes that feels really good, I didn’t realise I had so much tension in the area until we did this.’ My participation in the classes was often on the receiving end of technique practice, and enthusiastic comments like, ‘You get the good bit, you get to be the patient,’ or comments on the pleasurable experience of the ‘massage’ aspects of the techniques, were common. On the other hand, some effects are negative. The repeated practice of HVT techniques, especially in the third and fourth years, can have a negative impact on the structural integrity of the spine. One student explained, ‘When you have your back cracked [HVT] so many times it can lead to weaknesses in certain areas. Especially as the joints that crack most easily probably don’t need it all that often, but those are the bits that people find when they are practising.’ One student, after she had ‘three different people trying to do an HVT on me’, found that ‘that evening my rib popped out, and I’m still in a fair amount of pain [two weeks later].’ Another commented, ‘They say it takes five years to recover [physically] from this course.’ The student homeopaths are required to regularly explore their own health and experiences in class, to undergo regular homeopathic treatment throughout the course and to record their experiences in their learning journal. This formalises the requirement that students take seriously their own self-development and reflective skills. Through this the students put into practice the theory that they learn about the healing process on their own bodies.

The way that students experience themselves-in-a-body changes too. One osteopathic student said, ‘You don’t feel your body more, but you are more aware of the details of it.’ The knowledge and language of anatomy, for instance, creates new tools for exploring the body: one of the students runs a kung fu class for other people at the college, and he often uses anatomical and physiological descriptions to explain certain moves or stretches. These are terms that would not be familiar to most people

and are therefore inappropriate to use in a general class, but within the setting of the College it seems natural and passes without comment. For others, the embodied change is more profound. One mature student explained to me that doing the osteopathy course had enabled her to ‘get back into contact with my body’. She felt that years of teaching and not doing any form of sport has resulted in her feeling disconnected from her body. ‘I find this new relationship to be a very positive aspect of my training!’ she laughed. The training was for her more than just acquiring new skills but, ‘It is a journey for me, and I am really enjoying it.’ A final example illustrates a student’s embodied experiences of learning palpation, and relates it to her identity as an osteopath. She explained that some months before she had experienced a ‘crisis of confidence’:

‘Jane’ (Student): A few months ago I had this crisis of confidence... I started doubting the practice of osteopathy, serious questions around its effectiveness... and I stopped being able to feel anything when I touched people, which was so frustrating. But I decided to ask as many tutors as possible to explain to me what they were feeling, and slowly it came back to me.

NG: So do you feel that you are back to where you started now with your palpation?

Jane: No, something else happened. I felt that the whole experience actually made me stronger and more focused in my practice. About what aspects of osteopathy I was really in to. I now feel much more confident about my own style and about the treatment that I am giving.

Eventually, the students become accustomed to these new embodied ways of being, and so, in Bourdieu’s terms, they develop a ‘feel for the game’. This means that to a large extent they no longer have to consciously negotiate the bodily aspects of their interactions (Leder, 1990), focusing on the process and the patient rather than

themselves. However, it is also important to not overstate the changes; there may be some aspects of a student's embodied identity or their 'habitus' that may be resistant to change or modification. As Bourdieu stresses in his work, some cultural aspects of habitus are often deeply entrenched, such as class- and gender-based bodily characteristics. What is clear is that there are some very important ways in which the embodied sensitivities of the student practitioners do change, particularly in their interaction with others. Learning of homeopathy and osteopathy undoubtedly requires a change in the student's 'way of seeing' (for discussion of ethnography as a way of seeing, see Wolcott, 1999) or their 'somatic modes of attention', which are 'culturally elaborated ways of attending to and with one's body in surroundings that include the embodied presence of others' (Csordas, 1993: 138). Much of this learning takes place at an unconscious level. As an osteopathic student said, 'You know so many techniques and you don't know how you know them.' A homeopathic tutor said, 'Integration of learning takes place on an unconscious level and is demonstrated through altered behaviour.'

Conclusion

I emphasize the telling of illness stories as acts of *witness* and argue the centrality of witnessing in any ethics of illness. Both one's actions as an ill person, and one's actions toward the ill, begin with a capacity to recognize suffering and to communicate that recognition. This recognition ought to be self-evident, but sadly it is not (Frank, 1997: 105).

This chapter has explored the ways in which both the student osteopaths and homeopaths learn various methods to communicate their 'recognition' (Sointu, 2006) of the patient's suffering and to try to alleviate it. The healing process is recognised

to be more than just the result of ‘treatment’ interventions, but also about change and transformation in the patient at many levels. The practitioner can convey his or her empathy through a number of methods, such as touch or witnessing.

Learning to listen to body-talk involves gaining a snap-shot of the lived body, as it expresses itself at the time of the consultation. The concept also carries with it a hint of inertia; some aspect of the individual’s embodied narrative remains unprocessed, stuck or lacking in vital energy. This ‘stuckness’ compels the body to speak louder, moving from the general chatter of small aches (from exercise), dry throats (from thirst), or shivers (of cold or sexual ecstasy), to the shouts of mental instability, physical disease or prolonged emotional pain. The role of the practitioner is to listen attentively to the patient’s body-talk and to (help) construct a body-story to explain the current symptoms and to offer appropriate treatment or advice.

Undoubtedly, the construction of body-stories are shaped by the principles and theoretical frameworks employed by the profession. Hyden in his work on illness and narrative comments, ‘Literary and cultural conventions help both narrator and listener to construct the narrative’ (1997: 60). He also points out that, ‘The interest of researchers concerned with narratives and narration is being focused on *how* people talk about and present events - and not only on *what* is said’ (Hyden, 1997: 50).

The construction of the body-story is a key part in the healing process, either through recognizing the ‘legacy’ of the symptoms (osteopathy) or from ‘holding the space’ for the patient to make ‘connections’ between the symptoms (homeopathy). Bolton’s (1998) work on therapeutic writing in hospice care illustrates the healing potential of narrative construction. In this way, the function of the illness narrative or body-story goes beyond an explanation for illness or indeed a political move to

validate the lifeworld of the patient. The body-story itself forms the basis of healing either at a conscious, a physical or an 'energetic' level.

For the students, learning these new skills necessitates a fundamental change in the way that they act and express themselves. They learn new habits, ways of listening and ways of thinking, that impact on their own embodiment directly and on their interactions with others. The next chapter will move on from this discussion to an analysis of how the embodied 'theory' about health and healing is put into practice within the educational environment. Drawing on data in which students deal with 'real' patients, the chapter will explore how practitioners evaluate and are reflective about their practice and their skills in listening to body-talk and constructing body-stories. Additionally, there will be an exploration of the relative power relations in the construction of 'body-stories'.

SIX

Becoming professionals: power and the clinical experience

Introduction

At both colleges, students are required to demonstrate their ability to work with and help ‘real’ patients in student clinics and sometimes independently. The students need to learn to negotiate interactions not only with the patients, but with tutors and assessors and, perhaps most crucially, they are often challenged to learn new things about themselves through learning to work with others. The ‘ideal’ healing process, discussed in the previous chapter, is challenged in clinical settings, because of the increased complexity of the learning environment. Firstly, there are two aims of the student clinic which potentially conflict with one another: helping the patient *and* ensuring that students learn and develop their practitioner skills. Secondly, there is a three-way power relationship at play, between patient, student practitioner and tutor. This chapter seeks to disentangle this power system in order to assess the impacts on the therapeutic encounter in the student clinic as well as on the occupational habitus that the students develop.

Taking each profession in turn, I will explore the ways in which the therapeutic encounter in the student clinic is organized, considering specifically the extent to which it is geared to the requirements of the students’ learning as compared

to the patients' healing, and the implications that this has for the micro-politics of the encounter. I will then focus on the nature of the embodied knowledge that the student-practitioners learn in these clinical experiences and the professional 'bodies' that the interplay of embodied power produces.

Although this is the final analysis chapter of the thesis, I do not want to create an unproblematic 'order' to the learning process where practice simply follows theory – in reality, patient contact begins very soon into both courses and continues to be a significant component of the students' learning experience throughout their training. At the College of Homeopathy, students spend approximately a seventh of their contact time on patient casework in the first year (two hours per month) and a third of their contact time in the second and third years (eight hours per month). At the College of Osteopathy, the students spend one half-day a week in clinic in the first year, rising to three half-days in the final year. In addition, in many ways, the training only constitutes a bare start for the students; development of expertise and intuition comes through professional practice once students are 'safe' and 'confident' enough to go 'out there'. Unlike orthodox healthcare practitioners, who often work within healthcare institutions, there is often less support available for qualified CAM practitioners in private practice so safety on graduation is paramount, as well as being prepared to manage their own practices and having a commitment to Continuing Professional Development (CPD).

The Student Clinic - Osteopathy

The students' clinical experience is very closely supervised and produces complex patterns of embodied power. I will describe the therapeutic encounter to disentangle

the three-way power relationship in the clinic, identify the ways in which the clinical experience produces an ‘osteopathic habitus’ and consider the nature of that habitus.

Organising the clinical experience

Observation of the organisation of the College of Osteopathy’s student clinic reveals that the clinical experience is a very closely supervised process. The structure and organisation of patient-practitioner interaction is firmly controlled by the teaching staff. The students’ opportunities to exercise independence and discretion are limited in various ways.

The vast majority of teaching at the College of Osteopathy – classroom and clinical – takes place in a single building, although there are a few specialist clinics that students can elect to attend that are based at other locations. The clinic is located on the first and second floors of the building, as described in Chapter Three. The spatial and temporal organisation of the clinic environment gives insights into the social relationships between tutors, students and patients. There are two ‘staff’ rooms, one on each floor. In each staff room there are two ‘team points’ and each team consists of approximately twelve to fourteen students and three tutors. This is where most of the discussion and analysis of cases takes place, rather than in the treatment rooms in the presence of the patient. Sometimes the staff room is very busy, with many cases being presented and analysed, while at other times it is quiet with only two or three people in the room. Sometimes students and tutors sit silently working on writing up case notes or reading, at other times informal discussions take place. When there are fewer patients, sometimes the majority of the people in the room take part in a single conversation, at other times there would be a handful of

smaller conversations taking place. The ebb and tide of the day would dictate the type, tone and quantity of interaction in the room.

Patients who attend the clinic are either referred from local GP clinics or attend because the student clinic offers a low-cost service. They usually spend at least an hour and a half there. The consultation process is carefully organised providing the opportunity for detailed discussion of the case in order to maximise learning and ensuring that each case is adequately supervised. When patients arrive in the clinic, they come to reception and are checked in by reception staff. A call is made to the staff room to alert the appropriate student that their patient has arrived. The student then collects the patient from the waiting room and takes them directly to the treatment room. Patients are warned in advance that they are attending a teaching clinic and that there may be people observing their treatment. If there is another student (or myself) observing, the student in charge of the case asks the patient 'if it would be OK if my colleague sat in with us'. I never saw a patient refuse, although it may be that this happens sometimes. On a number of occasions, however, I saw students refuse to take in student observers (or myself) if they felt that the patient may not be comfortable with this. The student then takes an oral case history, described in the previous chapter, or follow up, using the standard patient records form.

The student then returns to the common room to discuss the case with a tutor, having asked the patient to undress down to his or her underwear while the student is out of the room. The student presents the case to a tutor, and the tutor confirms that the patient is OK to treat. They discuss ideas about what might be the problem, and the student fills in a section called 'Hypothesis/Ideas/Hunches (i.e. think widely not just diagnostically)' and they consider justifications for different hypotheses. At this point in the consultation, a tutor clarified, the students should be equipped with 'a

number of hypotheses which you look to confirm or deny by testing'. The student and tutor then discuss any special tests that the student should do, in addition to the standard ones. The student then returns to the treatment room and conducts a number of standing, seated and lying-down assessments of the patient to establish a working diagnosis. The assessments, the results of which must all be recorded on the patient records form, include 'General Observations' such as morphology, weight-bearing ability and muscle bulk. The standing and sitting examinations include things such as lateral curve, asymmetry and muscle states. Active movements, measuring quality and range of movement, and passive movements, initiated by the osteopath to check planes of movement and end point of movement, are both tested. All of these are standard processes that are taught to the students in first and second year Technique classes.

After conducting the physical assessments, the student again returns to the staff room to discuss with the tutor what information the assessments produced, what treatment s/he will give, and what an appropriate course of treatment and prognosis would be. The 'working hypothesis' is recorded on the form in five sections: predisposing factors, maintaining factors, physical factors, aetiology and emotional/stressor factors. Physical factors is given four times as much space on the form as the other factors. The students must also provide a 'summary' of the case by answering the question, 'Using your knowledge of osteopathic concepts, how have these factors combined to bring your patient to you now?' However, this section is more often than not completed after the patient has left, as students often find it very hard to do, and may rely on advice from their tutor. One student even said that 'in the third [non-final] year we just listen to what the tutor says and copy it down'. The tutor and student discuss treatment in detail using the 'Management' section of the

form which includes 'Short-term goals of treatment, and suggested techniques', then 'Long-term management'. Then the student must deal with prognosis in a section called 'Expectations – number of treatments required; Symptomatic relief will occur after ...; Functional changes after..., and To be re-evaluated after ...'. Finally, the student returns to the treatment room to give the patient 'the treatment'. It is very common for tutors to observe the students during this stage, or to assist with or demonstrate certain techniques. This, according to the tutors, is the core of what they do in the clinic – 'this is how teaching and learning and osteopathy happens'. Theoretically, tutors can sit in at any or all of the three stages of the consultation, although it is more usual for the tutors to observe or assist in the latter two stages.

After the treatment the student (and student observer if present) shows the patient back to the waiting room to make a follow-up appointment if it is needed and to leave. The student then returns to the common room to write up the notes, which includes the final part of the form, 'Advice given' (which can include general suggestions or exercises), 'Treatment at first visit and initial response to this', 'Explanation given to the patient', and 'Prognosis given to the patient (what you expect to achieve and time scale)'. Throughout the process there are opportunities for students to discuss their own responses to the case, and sometimes tutors will press students on their reflective analysis.

This organization of the clinical encounter can be considered to be responsive to the dual aims of the student clinic at the College of Osteopathy: the therapeutic treatment of patients and the educational development of students. Ultimately, the patients must be treated safely and effectively. Osteopathic treatment carries with it certain inherent risks, and it can be quite physically and emotionally invasive for the patient. The close supervision of students at all stages of the consultation aims to

ensure that potential risks are identified and minimized, and chances for effective treatment are maximized. In addition, this close supervision ensures that adequate time is assigned to the students for the discussion of ideas, experiences and treatment strategies, and that tutors have the opportunity to monitor and evaluate the capabilities and development of their students. The dual aims of the student clinic operate in tension with each other, and create complex patterns of power in the clinical environment, which will now be explored.

Participants in the clinical environment

Exploring each of the key participants in the student clinic at the College of Osteopathy – the patient, the tutor, and the student-practitioner – reveals a complex three-way interaction of embodied power relations that impacts on the experiences and the production of the bodies of those participants.

The patient, as a result of the tightly organized clinical encounter, has very little control over the interactions that take place, therefore, any ‘partnership’ model of patient-practitioner interaction is severely attenuated. In agreeing to be treated at a student clinic, the patient has, to a large extent, relinquished control over who can be present in the treatment room. The student-practitioners often bring in less experienced student observers, and the supervising tutor can come and go freely from the consultation. The patient has no control over the selection of a supervising tutor, which is the student-practitioner’s decision, although they can request particular students if they choose to.

The patient is also required to get undressed down to his or her underwear for the assessment and treatment stages of the consultation. While the students, at least,

have the initial case history stage of the consultation to see the patient clothed, the tutors rarely get to see the patient with his or her clothes on. In addition, tutors usually only ever give advice to students of a purely technical kind in front of the patients. This is not to say that tutors only concern themselves with the physical and technical aspects of the consultation. On the contrary, tutors frequently discuss with students the emotional and mental aspects of the case, both as it relates to the health of the patient, and as it relates to the experience and professional development of the student osteopath, but this is reserved for discussion in the staff room. Indeed, the discussion and analysis of the case happens almost exclusively in the staff room in the absence of the patient. During this time, the patient is left alone (undressed) in the treatment room, unable to contribute to the discussion and analysis.

One area in which the patient retains control is over their oral disclosure during the consultation. While the 'sharing' of personal details is a one-way process, the patient is able to resist the enquiring gaze of the student-practitioner and the tutor by withholding information. However, because of the nature of the osteopathic assessment of the patient (what was described in Chapter Five as 'listening to body-talk'), the 'body' of the patient may be saying all sorts of things to the osteopaths that the patient cannot control.

The tutors, on the other hand, are able to exercise a great deal of control over the clinical experience, in relation to both the patient and the student-practitioner, as well as to their own experience. Connected with this position of power is the relative invisibility of the tutors' bodies in the student clinic. While the focus of the tutors' attention is on both the bodies of their students (learning their trade) and the patients (being healed), their own bodies are rarely the direct focus of any participants' attention. When my attention, as a researcher, was drawn to the bodies of the tutors,

it was invariably in relation to a demonstration of their superior control over their environment and bodily presentation. For example, all tutors and students are 'required' to wear white coats in the student clinic, and while most tutors do wear white, or sometimes blue, coats, a significant minority do not. These tutors do not wear white coats in their own private practice and refuse to do so in the student clinic. A more detailed discussion of the wearing of white coats is developed below.

The tutors adopt a flexible approach to teaching necessitated by both the variety of roles they must fulfil in relation to the students – supervisor, teacher, coach and assessor - and the varying abilities of those students. To a large extent, the relationship is supervisory. Tutors retain ultimate responsibility for the patients and students must get every case signed off by the supervising tutor. Because of this, tutors employ informal rules around what students are allowed to do unsupervised. For instance, non-final year students are rarely allowed to HVT a patient without a tutor present. During the period of time I was conducting research the staff had negotiated different insurance liabilities, so that they were not personally responsible for each patient, rather that the liability fell with the college for student treatments in the clinic.

In addition, during each half-day session there is usually a formal tutorial taken by one of the team's tutors where s/he may bring together issues that have arisen during the day, present information, or provide a forum for discussion and debate within the clinic team. This is a more formal teaching and/or facilitating role. The tutors also perform a coaching role, encouraging the students to develop habits of thought and action that are required to develop competency and eventually expertise, and to pass the assessments. Towards the end of the fourth year, in preparation for the final clinical competency (FCC) exam, the tutors often focus on asking the

students challenging questions ‘on the spot’ in order to help prepare them for the exam by improving their ability to justify their therapeutic actions, and to discuss the social and psychological aspects of the case. Finally, the clinic tutors have a role as assessors, because students are subject to ongoing assessment in the clinic. Tutors are required to write reports on student performance and progress. This role is potentially in tension with the role as coach and supervisor, and it may prevent the students sharing problems with them.

However, the balance of informal and formal methods of teaching is essential to the functioning of student learning in the clinic. Tutors are usually happy for students to call them by their given names and tutors and students sometimes socialize outside of college, for instance at the local pub on a Friday night. In clinic, there are regular informal ‘professional conversations’ between students and tutors, which allow students to explore aspects of ‘being an osteopath’ that may not be addressed in the official curriculum, such as the management of ‘difficult situations’ or additional practical questions about running a practice. As will be discussed further below, it is through these conversations that many of the embodied aspects of professional identity are made explicit. The emphasis of the relationship that the tutors have to the students varies according to the year of study and the abilities of the students.

Generally, tutors give closer supervision and more support, especially on the technical aspects of diagnosis and treatment, to the less experienced students. As they move into their final year, when as one tutor said, ‘We see them more as colleagues,’ they give the students more leeway and show more confidence in their decision-making.

While tutor-student relationships ranged from friendly and informal to challenging and formal, I witnessed nothing that I would describe as ‘teaching by humiliation’ that has been observed in medical teaching environments (Cassell, 1998:

80). The closest example that I found was a female tutor who went in to observe a final year female student with a patient. She grilled the student about the case, asking a number of very specific questions to which the student stuttered and was unable to give clear answers. The student seemed nervous and uncomfortable, which may well have been exacerbated by the patient's and my own presence. The tutor never contradicted what the student said, nor made any disparaging comments, but continued to ask questions even when it was apparent that the student was really nervous. Afterwards, the tutor said to me that the student really lacked confidence and that she was concerned about her ability to pass the clinical exams, where she would have to answer direct questions about what she had found and what she was doing. I tried to speak to the student later in the day, but found that she was always 'busy'. As she was clearly going through a difficult time, I felt it was inappropriate to force a conversation.

Through professional conversations, assessment, and supervision, the tutors have the power to shape the experience of students and create the 'realities' of the osteopathic world. Although individual tutors may have limited control within the whole institutional structure of the college, at a micro-political level they enact the power of the institution to define with makes a competent osteopath and their 'embodiment' of what it means to *be* an osteopath is profoundly influential for students.

The student-practitioner's role in the clinic environment is complex because s/he is both responsible for the welfare of the patient and for negotiating his or her own learning. In some ways the students' embodied experience is more aligned with the patients', as their own bodies are also subject to the scrutiny of others. The students' ability to perform as a professional – 'being an osteopath' – is being

observed, so they must pay attention to their own embodied self-presentation.

However, in other ways, their embodied experience is more closely aligned with that of the tutors, as they also wear professional dress (such as the white coat and ‘sensible’ shoes) and are party to the discussion and analysis of the case.

The student-practitioner’s experience, especially in the early stages of taking responsibility for patients, is precarious. The students are confronted with the ‘realities’ of practice and ‘being’ a professional, while still feeling like a novice; they are, as one tutor put it ‘thrown in at the deep end’. In the clinic, even more than in the classroom environment, the students are not, indeed cannot, be passive learners. They, in an accelerated fashion, construct and negotiate their own professional identity, and learn how to deploy their own embodied skills and knowledge appropriately. As noted in Chapter Four, they are also able to ‘play the game’ in order to demonstrate their abilities in assessments.

Student-practitioners critically reflect on their interactions with tutors. Especially in the final year, with increasing confidence in their abilities, students are often able to be critical of the supervision they receive, and adapt it accordingly in their own practice. They begin to realize that there is no one answer or correct interpretation of the patient’s case. Discussions I had with students showed that over time they became acutely aware that they could present exactly the same case to two tutors and get very different responses and advice. The more mature or experienced students seemed better equipped to deal with this uncertainty, and would seek out particular tutors who they saw as having expertise in particular areas, according to their patient’s complaint, while the less experienced students struggled and would say things like, ‘But so-and-so said...’

The micro-politics of the student clinic are clearly bound up with issues of embodiment and interaction. The separation of the analysis of the case is clearly an advantage for students, as it gives them the opportunity to develop critical and reflexive analysis skills, through exploring a wide range of diagnostic possibilities and treatment options, without having to pay attention to the impact that this may have on a 'vulnerable' patient. Yet, this may *produce* an embodied professional identity that is tied to a partial distribution of power and control over the therapeutic encounter and the bodies of the participants. It is the production of the osteopathic identity and 'habitus' through interaction with patients that I turn to next.

Producing osteopaths

The outcomes of the clinical experience for students, mediated through the exercise of embodied power, are both the ability to competently practise osteopathy and the embodiment of the 'osteopath' identity by the student-practitioners. As noted in Chapter One, for Bourdieu, the habitus is 'a system of lasting, transposable dispositions which, integrating past experiences, functions at every moment as a matrix of perceptions, appreciations and actions' (Bourdieu, 1977: 83), and knowledge is always *constructed* through the habitus, rather than being passively recorded (Webb et al., 2002: 38). If it is going to be possible to conceptualize the outcomes of clinical training as the development of an 'osteopathic habitus', it is necessary to explore both the unique habits of thought and action that the student-practitioner develops, and the management of his or her own body in relation to others (see also Goffman, 1959). Students must manage their own precarious bodily boundaries, in particular the 'the dialectic of distance and intimacy' (Churchill &

Churchill, 1982, cited in Greenhalgh & Hurwitz, 1998: 5). A 'professional' habitus distances the professional from other practices, particularly sexually intimate ones and other forms of (lower status) employment that involve direct touching and contact with the body.

I turn first to the process of developing habits of thought and action appropriate to professional osteopathic practice. The development of these skilful habits is mediated by the power relations described above, and the student must be able to demonstrate his or her ability to assessors. The trope of the detective was regularly affirmed in the clinical environment as an ideal-type model of the role of the osteopath in the healing process. The students are also encouraged to deal with the uncertainty of the detective process, through careful recording of their analysis and reflective practice. One of the professional requirements for the osteopath is 'An ability to deal with uncertainty effectively and efficiently without loss of professional self-confidence and the ability to manage the case' (GOsC, 1999: 8).

Students are encouraged to be precise with their questioning about presenting symptoms, in order to find out what they need to diagnose and treat the patient osteopathically. In one example, a student while presenting a case could not answer a specific question from the tutor about an aspect of the patient's symptom picture, and the tutor said, 'Don't just take it from her, put it back [ask questions], reflect what she has said back to her and clarify... this gives a more accurate picture... people often forget or don't think it is relevant, so ask.' One tutor explained, 'It is like being a detective, you have to feed in all the clues looking to implicate certain structures but also to rule out others. It is an exciting process!' Tutors give a lot of advice on this detective-like analysis process. For example,

Write down hypotheses and then say why they are not true.

If she [the patient] is not getting better then you need to hunt around and look for things. Take a step back and look more generally at the case – sometimes just by doing that you can get a lot of ideas about possible links.

You start to think about all the things that might cause pain in that area... It would start to give me a sense of what tissues are involved... If [after an injury] it became painful immediately, the tissue must have a good blood supply... if the pain came on over 12 hours, the tissues would be ones with a less good supply such as a ligamentous structure.

If you know the range of tissues that could be involved and the range of pathologies that are related to those tissues, then you can figure in other components such as when it happened or how it started.

The thing to remember with this is that there is not one answer... it is often a compounded thing.

As noted above, tutors perform a coaching role by conducting careful step-by-step and in-depth questioning of the students, that requires them to recall abstract knowledge that they have learnt in academic classes in the context of particular cases, such as, ‘What aspects of the neurological system do they [reflexes] test?’ This is often very hard work for the students, and can cause them a good deal of apparent stress or confusion when they cannot answer questions, but provides the opportunity for repeated rehearsal of their ability to *think* osteopathically, which will be tested in their Final Clinical Competency examination.

In addition, the tutors often get the students to think holistically about the case so that they do not become too closely focused on the ‘pain-causing structures’.

Examples of advice and comments from tutors include:

Find out how this condition is affecting the person’s life. You are not just a passive observer.

You are interacting with the patient. Trust and respect is very important both ways. If you explain things to them you are more likely to get a true picture from them.

If someone comes in and says I have MS, I ask, how does it affect your life? Not all people diagnosed with MS have all the symptoms and it is important to find out exactly how each person is affected.

In one case of a young woman presenting with a number of physical and emotional symptoms, including back pain, stress, panic attacks and nightmares, the student, Bea¹⁵, and tutor, Emma, were discussing what to do. The patient had another woman in the consultation with her who she kept looking to for reassurance whenever she answered a question. Emma and Bea discussed that maybe after three or four treatments the patient might feel comfortable enough to come on her own, as Emma put it, ‘once she realized that she didn’t need the other woman along.’ They speculated that the cause of the stress might be some sort of abuse from a man, but Emma stressed that they should not make assumptions. They discussed what Bea should do in terms of osteopathic treatment physically, with Emma trying to draw out the motivations of various potential treatments, and getting Bea to justify her hunches. Emma also gave the advice, ‘Give her the space to feel safe and maybe talk about the cause or origin of the stress *whilst doing your job [my emphasis]*.’ In this way, the

¹⁵ All names have been changed to preserve the anonymity of the participants.

physical work was implied here as the priority and the essential aspect of osteopathic treatment, with 'soft skills' as a important supplement to this.

However, the management of emotions sometimes played a more central role in the healing process, and generates challenges for the osteopath-as-detective. In fact, one of the assessment requirements for the students is, what they refer to as, the 'concepts case' in which they must write up a real case they have managed in clinic that brings in all they have learnt about in Conceptual Basis of Osteopathy, including osteopathic principles, sociology, psychology and history. In one example, the tutor, Ann, discusses a case with a student, John, and mentions that this case might be a good one to write up for the 'concepts case', as emotions and social factors play a big role. John talks through the case history with Ann following the basic format of the first stage. He mentions after going through the physical symptoms that he found the woman 'really unpleasant, rude, bristly, short and also kind of beaten even at the age of only twenty-six.' He has discovered that she was very stressed about her work: 'She has recently been promoted to supervisor and is finding the extra workload unreasonable, and she has no one to talk to about it at work.' Ann goes into the consultation with John to help him with the second stage of physical tests (although I do not observe this). On returning to the staff room, Ann offers technical input, such as, 'I observed that she pinked in the ribs when touched which is a sign of hyperventilation,' but also suggests to John that he should not talk to her about work during the treatment because it was clearly a cause of stress to her. John returns alone to the patient to treat her. On returning to report his progress and treatment, he says, 'I was really worried to start with as I was treating her because she started to talk about her work, and you had said I shouldn't... she was carrying all the stress in her shoulders... as I was treating her she started to chat about her work and then started to

relax, to let it all out, and I could see a real improvement in her muscles... as she started to relax she became a much nicer person!’ Ann said to John that this was a ‘real changing point for you in terms of your thinking about patients.’ They then had a joke about using the term ‘reflect’ because of its status as a ‘buzz’ word in health care at the moment. Ann said she should use it ‘to impress the PhD student... look I got it in!’ Afterwards, as I was talking to John, he said, ‘There are moments of realisation during the course, when you suddenly get something.’ He also reflected on the patient’s attitude at the beginning: ‘I guess part of her possible reluctance was that the doctor has sent her and possibly she was just interested in getting a doctor’s note to get time off work... [pause] which she needs!’

The ‘detective’ is an active agent in the healing process, with the power to define the ‘problem’ that the patient has, to make the patient aware of aspects of his or her embodiment from an osteopathic perspective, and to physically manipulate the patient’s body. This can cause tensions for professional identity about the relative responsibility and control that the patient and practitioner have over the process and outcomes of treatment. For example, one young male student told me that he didn’t like to ask questions to fill in the box ‘Patient’s View of their Problem’ because he felt it made him look stupid, ‘I feel it undermines my position and my knowledge.’ But an older female student who overheard our conversation said that she felt it was ‘really important’ to ask that question, as it could give ‘different insights, the patient may reveal more, like possible fears or concerns’.

Some of the terminology used to negotiate the patient-osteopath relationship mirrored orthodox medical terms, such as ‘non-compliance’. An example of this was a patient who had been recommended by her osteopath to stop her yoga practice. The tutor said, ‘Patients may also ignore things that you tell them that don’t fit in with

their ideas so bring the conversation back to that again. This patient thought that yoga was good for her, and didn't realize that she was doing it so much it was stopping her getting better. She had unreasonable expectations from her treatment. She said she wanted to do a cycle race in two weeks, but wouldn't give up the yoga.' However, in general, there was evidently a balance to be struck between this more paternalistic approach, and the partnership model. Another tutor said, 'If you say "stop smoking" to them you'll seem judgemental and domineering... talk around the issues, make it clear that you will be supportive if they do decide to give up. Wait until you have rapport to talk about things like weight issues etc. so that you are an ally rather than judgemental.'

Perhaps in part to mediate some of these tensions, the students are required to learn and demonstrate reflective practice. Students are called upon to bring a critically reflective approach to their practice, not only in terms of their osteopathic treatment techniques, but in the analysis of the social and emotional conditions of their patients and of their own social and emotional responses and positions in relation to those patients. This is an important productive outcome of the 'separation' of the case analysis from the patient because the students can more consciously reflect; the tutors have the opportunity to challenge the students about aspects of their practice, and the students are able to demonstrate their learning of reflective practice to the tutors in the ongoing assessment that takes place in the student clinic.

For example, a student, Chaada, was having a discussion with her tutor, Daniel, about the fact that she was finding herself getting 'really annoyed and irritated' by a patient. He suggested to her that it was 'not enough to *perform* empathy, you really do need to empathize with the patient. For instance if the patient is not doing their exercises and you just tell them off about it...[that is not good

enough]. We are supposed to be patient-centred practitioners.’ They talked through what was causing the problem and she said, ‘I felt undermined by the patient, like I was being of no use.’ Later in the day, Chaada approached me in the Student’s Union and said, ‘That must have been a really interesting discussion for you,’ and we talked about it. She said that she agreed with Daniel that, ‘I need to be genuine in my empathy with patients or they aren’t getting the best treatment... so I’ve passed my care [of the patient] onto Jeff [another student]... My purely physical techniques with her [the patient] are fine, as good as I can do, but the rapport is just not there.’ She explained to me that she intended to write about this case in her reflective portfolio as a learning experience.

The osteopaths return frequently to the idea of objectivity, particularly in relation to their practice, ‘symptoms are subjective, and signs are objective’ is repeatedly affirmed by tutors and lecturers. Nonetheless, with a sociologist’s sensitivity to the uses and abuses of claims to objectivity, I often probed further and found that objectivity was conceived as being set in the context of reflective practice and boundary setting. Tutors and students talked about ‘avoiding uncontrolled empathy’, ‘boundaries in practice’, being ‘in tune and in control’ of feelings. Many of the opportunities for learning these skills occur in the clinic environment. Nonetheless, there was still an emphasis that was less apparent among the homeopaths (discussed below) to view the practitioner’s role as ‘expert’ or ‘specialist’ in terms of being in possession of a deeper or more ‘real’ understanding of the patient’s condition than they themselves had access to. This was reinforced by the diminutive amount of space given for documenting the ‘patient’s view of the problem’ on the patient records. The privileging of the osteopathic way of knowing is vital to the construction and commitment to an osteopathic identity and becomes

ingrained in the habitus of the practitioner, through his or her ways of perceiving and acting in relation to patients.

In addition to privileging the osteopathic way of knowing *vis-à-vis* that of patients, conversations in clinic often served to distance osteopathy as a healthcare practice from other professions, particularly orthodox medicine, chiropractic and physiotherapy. Often this took the form of overt or covert criticism of other professions. For instance, one tutor reported to a group of students in the staff room about a case of a patient with severe back and leg pain. He explained that the patient had been to see a chiropractor in the US and since then had had severe pain. He said, 'I can't believe that they ['the chiropractors'] just cracked [HVT treatment] someone with these problems. So my diagnosis for the case was over-treatment, over-manipulation.' In a group tutorial during one student clinic afternoon, the tutor showed the students a page of physiotherapy exercises that she had been given after breaking her arm. She asked the students to look at them and suggest what they might do differently, then added, 'not that I'm slagging off physiotherapists!' Nonetheless, it is interesting that she felt that she had to defend herself against the implication that she might 'slag off' a physiotherapist, as increasingly the new regulation of osteopathy is encouraging osteopaths to adopt more integrative principles with other healthcare professions. In another physiotherapy example, the tutor said, 'You have to do inhibition [a treatment involving pressure on a tense muscle] and palpation at the same time. Don't just hold it for a set time like physiotherapists. Listen to the muscle. Once the muscle has relaxed it is pointless carrying on'. In relation to orthodox medicine, one example was, 'Structure is more important than function as far as the GP is concerned,' referring to the case of a clinic patient for whom the GP

would not do a hip replacement. These examples serve to reinforce the ‘distinctions’ of osteopathy in the value-system of the students.

I now turn to a closer examination of the ‘body’ of the student-osteopath and how it develops during the training process and becomes distinct from other bodies, by producing boundaries that come into play in the physical and social interaction with other bodies (and bodies of knowledge). A key problematic in the power relationships in the therapeutic encounter is managing ‘the dialectic of distance and intimacy’ (Churchill & Churchill, 1982, cited in Greenhalgh & Hurwitz, 1998: 5). While practitioners create intimacy in ways such as physical touch, which are essential to professional identity and practice, they also seek to maintain professional distance and distinction.

The management of bodily boundaries is a complex process. Students learn the importance of ‘touch’, not only in terms of osteopathic manipulation and treatment, but also for its role in conveying care to patients. One of the students, Jenny, was talking to her tutor, Pippa, about how she had been working on adapting her technique because her elderly female patient had a bad wrist. She said,

I’d been working in a semi-recumbant position on her thorax area and this week the patient came back and said that she had been talking to her friend about how she had ‘got all huggy last week’ in her osteopathic treatment. Her friend had said that she got that too when she came to the clinic.

The tutor and student discussed how therapeutic touch was such an important aspect of the treatment experience often especially for older people, and Pippa asked Jenny to consider a number of questions carefully: ‘Do you think that patients can become reliant on you, or the treatment?... So what else do you think that the patient gets from

coming here?... Could there be a case where a patient was too reliant and you should stop treatment?’ Jenny considered this and said that she thought the patient got ‘time to herself here, away from domestic responsibilities, and for the touch... it is difficult to make that decision [to stop treatment] with a chronic condition like osteoarthritis in the knee. I don’t think that we could justify not treating her.’ In a similar vein, a student was explaining to me that it was important to maintain boundaries around care: ‘You have to avoid dependency in the patients.’ However, she said that it is sometimes difficult and that ‘as a practitioner you have to realize that for some patients it is part of their social life to go and see their osteopath. Especially for elderly patients, it may be the only form of touching that they ever get.’

As well as boundaries around dependency, ‘hugging’ makes visible problematic boundaries around sexuality, as this conversation demonstrates:

Student 1: I sometimes get around the hug thing by when you have finished with them on the plinth, if they find it difficult [to get up] I say, ‘Let me help you,’ and put my arms around them to pull them up [demonstrates on student 2 by moving her from behind the shoulders].

Student 3: Yes, but not on men, pushing these in their face [wiggling her chest].

All the students in the conversation laughed and the point was clear that it was important to avoid ‘crossing the line’. In one tutorial, students were told ‘be mindful of how patients may be uncomfortable being “on display”, especially women patients with men. Talk them through everything, keep professional, make them feel like it is a completely normal situation.’

In another example, students were discussing in a tutorial:

Tutor: Be aware though, some patients can be over-familiar, they can be predatory, and want to know lots about you

Student: But you are finding out lots about them, isn't it fair that they should want to know something about you.

Tutor: They don't need to know anything about you.

It was my feeling at this point that the student's point had been dismissed somewhat, perhaps because it did not fit into the model of professional conduct that the tutors envisaged. The conversation turned to the possibility that professional boundaries could be threatened by the misinterpretation by the patient of the care and attention s/he received from the osteopath.

Tutor: There is a risk that they [the patients] might fall in love with you... because you listen to them and they might not have that in other parts of their lives, they may misconstrue your interest as more than that... be aware that you are in a position of power.

Student 1: But we are not trained for this stuff!

Tutor: But people deal with it differently – you learn from experience, in the clinical environment you are supported in this learning... If you reject a patient [’s advances] it is possible that they could make a complaint against you, so keep evidence to back you up ...

Student 2: I've heard that sometimes patients don't wear underwear.

Tutor: This compromises the situation for you. Keep professional, there is a fine line between making too much of an issue of it and keeping professional.

In this last comment, it was unclear exactly how a patient should 'keep professional' in terms of actual bodily interaction. Sexuality in healthcare work is a taboo subject but the intimacy of the situation challenges some of the conventional boundaries (cf. Oerton & Phoenix, 2001). This creates uncertainty and a feeling of insecurity for the

students especially at the early stage of training, where they have very little experience of working with patients.

Another issue related to taboo and the construction of the osteopathic habitus, was brought up in an informal clinic conversation between students and tutors. One student had returned to the staff room and was vigorously washing his hands. He commented to those present that his patient had been really smelly, sweaty and dirty. There was some joking, and one of the tutors suggested techniques to prevent it happening again, such as telling the patient that it was useful to have a hot shower or bath 'to loosen up the muscles' before coming in for a treatment. One of the students said that he thought that 'presenting yourself clean' for an osteopathic consultation was indicative of 'respect' for the osteopath. This is interesting as it demonstrates that for these osteopaths, their own practice should fall clearly on the side of 'clean' in any distinction between 'clean' and 'dirty' work.

Clothing was one of the key ways in which the body of the osteopath was made distinct to that of the patient. As well as the issue of patients being undressed in the consultation, described above, the deployment of the 'white coat' in the clinic symbolized interesting negotiations of boundaries and embodied distinction. One member of staff alerted me to an online discussion, on the staff forum, about the wearing of white coats in osteopathic treatments generally, and in the student clinic specifically. An analysis of the key arguments, using codes, for and against their use was illustrative of both the varied perspectives that osteopaths have about embodied power relations in the clinical encounter and the unique position of the student osteopath in these relations. The discussion itself became quite heated in parts, which I felt reflected the controversy of the subject to some extent but also the perceived differences in professional 'pride' in osteopathy.

Those arguing ‘for’ white coats in the student clinic evoked general ideas of positive barriers, both physical and social. Hygiene, or perceived hygiene was considered vital by most contributors, and an important value to instil in the students. The ‘barrier’ or ‘distance’ was also an important ‘reassurance’ for patients because

the hands-on element of osteopathic treatment involves the invasion of the patient’s personal space in a way that’s clearly inappropriate in (most!!) social situations, as is the necessary element of personal disclosure to a stranger when discussing one’s personal physical functioning. Isn’t the white coat a device whereby a potentially stressful, intimate situation can be ‘desocialised’ with beneficial effect?

This social barrier effect was also seen by various discussants as important for the students’ confidence to ‘help [them] to negotiate the difficult early stages of practice’, to ‘protect’ them, to give ‘an aura of professionalism’ and to ‘formalize the situation’. Indeed, one member of staff said that wearing a white coat could be ‘therapeutically empowering’ for students. Another suggested also that this barrier effect of wearing a white coat could also be essential in some professional situations, especially when treating friends ‘when I need the symbol to signify the difference in the therapeutic rather than friends relationship’, and ‘because my practice is in my home and it helps the barrier between home and work’. Other suggestions of why the white coat was important included the idea of a ‘positive placebo effect’; avoiding the possibility of students ‘acting the consultant’ in a suit and tie, and quite simply the benefits of the ‘school uniform’ idea of having a ‘house style’ to avoid problems of poorer students finding appropriate professional clothing.

Arguments ‘against’ white coats critiqued the benefits of the barrier effect arguing that this might lead to ‘patient dependency’ through ‘addiction to

compassion', by 'giv[ing] a sense of more therapeutic power than is reasonable, so that the patient attends under false belief/hope' or by 'prevent[ing] patient awareness and empowerment'. They argued that professional status creates unwanted barriers in the healing encounter, particularly in the children's clinic where evidence suggests that 'children need to feel close enough in a personal way to someone before they will relate to them. They don't relate to people in white coats so they don't talk to them.' This was linked to an argument that osteopathy cannot and should not be 'depersonalized' or 'desocialized':

[This means]... the practitioner depersonalizing the patient, treating him/her as an object or seeing treatment as an end in itself. In its worst form the medical model may lead to this when the focus is entirely on the disease, though I think it is uncommon for any primary care practitioner (including GPs) to practise in this way... Where osteopaths have an advantage is that we touch patients which, although it can be done impersonally... is usually perceived as a personal act. Here we perhaps need to bear in mind... that for some patients the visit to the osteopath [is] the only physical contact they [have] with another person – particularly in a caring context.

Care, in these arguments, was seen as crucial to the therapeutic encounter, at least equal in importance to treatment. Hygiene was also cited as a counter argument to white coats: 'I was interested when visiting a hospital recently that they'd switched from white coats to blue coats, because the test they'd done showed that white coats were perceived as more hygienic – and therefore washed less frequently!'

The discussion became heated over the issues of professional 'pride' and distinction. One tutor argued that:

White coats seem to be worn by cleaners, nurses, laboratory staff and the lower orders. I think a major part of my dislike of white coats is that I don't consider myself to be part of this medical minion group. By not wearing a white coat I am aligning myself with the dress code of the professional rather than the manual worker. Obviously osteopaths are far superior to doctors, but I'd rather my patients perceive me to be more like a doctor than a medical auxiliary.

He received, however, strongly worded opposition:

The arrogance contained in these few words terrifies me in many ways. Where is the evidence for your claims? Can you carry out a heart transplant, perform psychological diagnosis and treatment to a specialist level, etc. etc.? There are things we do well and there are things we do badly just like other healthcare professionals. One of my problems on a personal level about osteopathy is the guru led feeling that we are the best and everyone else is rubbish. How can we expect our students to be critically reflective about practice when it appears we are just critical about everyone else.

Another respondent said:

If the criteria for being top of this tree relates to effectiveness in terms of improving health it's probably those 'lower orders' or activities like cleaning that you mentioned a few posts ago that are up at the top in terms of the health of the nation! Prevention and health promotion have bigger impacts on health than practitioners. In terms of the professions I think collaboration and partnership are the ways to go forward. I worry that an inflated sense of professional importance puts self identity and the professional role at the centre of a model of health care whereas it should be the patients that are at the centre getting the best available care from whomever can offer it with the right skills.

The complex meanings assigned to the osteopath's presentation of self, through clothing, illustrates the way in which the osteopathic habitus is negotiated and deployed intentionally in certain social fields.

Ultimately, the students' clinical experience is productive of 'the osteopath' as a functioning social agent, adept at negotiating the complexities of knowledge and embodied power in the therapeutic encounter. Clearly the institution is able to exercise power (through the tutors) because it can define 'the osteopath' through assessment of clinical competence. However, the discussion has shown that not only do students negotiate and construct their own habits of thought and values, rather than passively absorbing them, but that professional values and practices are far from homogeneous in the first place. Debate and discussion is integral to the development of any profession, including osteopathy.

The Student Clinic - Homeopathy

The student homeopaths are encouraged to start working with real patients as soon as possible, prescribing remedies for acute conditions within their family and taking whole cases for friends or acquaintances. They attend tutorials in which they can discuss these cases, relate their own experiences and listen to each other. In the second and third years, students also attend student clinics where their case taking and analysis is observed and closely supervised by a clinic tutor and the other students in the group. As with osteopathy, the clinical and tutorial learning environment produces unique and complex embodied power relations between patient, tutor and student-practitioner, that threaten the 'ideal' healing process discussed in Chapter

Five. Nevertheless, the experience of learning to practise homeopathy is vital to the production of the students' professional identity and habitus.

Organising the clinical experience

At the College of Homeopathy, there are two learning environments that support the students in their management of real patients: tutorials and student clinics.

Observation of these learning environments reveals that students are required to take cases both independently and with close observation and supervision. Developing the ability to manage their own cases is incredibly important, as most homeopaths work in private practice, yet the tutors also need to have the opportunity to observe students working to offer advice for the development of skills, and to assess their abilities.

Tutorials take place outside of the college building, usually in the tutor's private clinic or home. Tutorials run once a month, between college weekends, for two-hours. Members of the tutorial group (maximum six students) can be from any year group, and so there is usually a range of abilities and experience in a group. The tutorials operate in a very flexible format. Students are asked to bring cases they are working on (not student clinic ones) for discussion in the group, but personal and non-patient related questions or contributions are welcomed as well. As it is a small group and because of the location, the atmosphere can be quite intimate. Some tutors burn candles or incense and have relaxing music playing while the students arrive.

Whatever the physical set-up of the room and environment, the aim is to provide a 'safe' space for students to discuss their case taking and their own experiences more generally of the course, but there is inevitably variety in the 'feel' and atmosphere in these classes.

If students bring a case for discussion, they ‘present’ the case to the class in detail, relating the patient’s words *verbatim* where possible, and explain how far they have got with their analysis. Sometimes the student has already prescribed for the patient, but wants advice about writing the case up or about how to follow-up the prescription. The time taken over the cases is flexible, and discussion can be detailed and multi-dimensional, or can just be on one or two aspects of the case that the student is struggling with. The patients are obviously not present for this discussion, although students are required to explain to their patients that they may take their cases to a tutorial group for supervision and confidentiality is assured.

The student clinics offer an environment for much closer supervision by tutors. Student clinics run once a month between college weekends, usually for about six hours. Students are required to take and analyse cases in the presence of a tutor, and to observe other students working with patients. The members of the student clinics use a variety of methods of attracting patients, including word of mouth, leafleting, posters in the health clinic and advertising in local papers. At the beginning of the day, the students and tutor gather and prepare for the different cases by revisiting the cases and reminding those present of what has happened in previous consultations. The consultation room is usually arranged with two chairs facing each other next to or over a small table at one end of the room for the patient and the student-practitioner, and the other students and the tutor sit on chairs facing them at the other end of the room.

When the patient arrives, the student-practitioner in charge of the case collects them from the waiting room and brings them into the consultation room. The student-practitioner will introduce the other people in the room to the patient and then the consultation will commence. Because of the nature of homeopathic case-taking, the

patient will talk for most of the consultation, with occasional prompting from the student-practitioner. The student-practitioner makes notes, and attempts to employ his or her skills in ‘listening to body-talk’ as described in Chapter Five. Once the student has finished taking the case s/he has the option to ask the patient, ‘Would you mind if I asked the others if they have any questions?’ If the patient agrees, the other students and the tutor may ask a few questions picking up on details that they feel the student did not cover, or probing further in an area of the case. Once any additional questions have been asked and answered, the student-practitioner responsible for the case would ‘close’ the consultation by asking any additional comments or questions, checking whether the patient had anything to add (and sometimes they did), and taking the patient out of the consultation room, collecting payment and making a follow-up appointment.

After the patient has left, the students and tutor begin their analysis of the case and make a prescription. The depth and pattern of the analysis varies depending on the tutor in charge and the amount of time the group has for discussion between patients. Generally, the student who has taken the case leads the discussion, guided by the tutor and responsive to questions and comments from the other students. Often the discussion will cover the various aspects of practice that students are expected to include in their written cases for assessment. The analysis process is not formalized on standard patient records forms like at the College of Osteopathy. Indeed, some tutors specifically request that students do not always follow the same pattern uncritically. However, there is still evidence that students learn to think about cases in a distinctively ‘homeopathic’ way. The discussion is both reflective and analytical. Usually the reflective aspects will come first. The tutor or other students

may comment on how the student conducted the consultation offering praise and constructive criticism, or the student-practitioner may raise his or her own concerns.

The analytical aspects of the discussion usually begin, if the consultation was a follow-up appointment, with looking at how things have changed since the last appointment for the patient. The students check back on what was prescribed and assess the extent to which the remedies did their job, or had little or no effect, and which may need to be continued. They consider both the patient's interpretation of the effect of the remedies and their own interpretations. The second aspect of the analysis that the clinic group does is what needs to be healed: 'What are the key things that need to move forward for this patient?' The next step is to consider, on the basis of what needs to be healed, an appropriate 'methodology' for the case. This may include aetiological, therapeutic (concentrating on a particular aspect of the body's dis-ease) or holistic (constitutional) prescribing, although there are others (see Watson, 1999). The group will then discuss which remedies or flower essences may be appropriate. They look up rubrics in the repertory, and check the detail of possible remedies in the *Materia Medica*. Finally, once a remedy or group of remedies has been chosen, the decision will be made about remedy potency. For this decision, the students think about questions such as 'Energetically, where is the patient?' or 'What are you *intending* the remedies to do?' After a prescription has been created, the tutor will usually check with the student-practitioner who took the case that they feel completely happy with it, and then that student is responsible for sending the remedies to the patient. It is considered to be of vital importance that the prescribing student feels confident in the decision, because of the centrality of the patient-practitioner interaction in homeopathic practice.

Participants in the clinical environment

The organization of the support for and supervision of student case-taking at the College of Homeopathy produces a complex web of embodied power relations, particularly in the student clinics. Taking each of the participants in turn – the patient, the tutor and the student-practitioner – I will explore how these power relations impact on their experiences in both contexts.

The patient is not present for the analysis of his or her case at either the tutorials or the student clinic. As in the case of the osteopathic student clinic, in the final instance, the separation of the analysis from the patients means that the homeopaths' interpretations are dominant. For cases brought to tutorial, however, the patient and the student-practitioner have usually been in a one-to-one relationship, whereas the patient at the student clinics is observed, discussing potentially intimate physical, emotional and spiritual aspects of their lives, not only by the student-practitioner, but the other students and the tutors as well. Patients have already been informed of the set-up of the clinic by their student-practitioner before agreeing to a consultation, but once they are there, they essentially relinquish control over who is present.

The patient will talk for most of the consultation, with prompting from the student-practitioner occasionally. For some patients, this comes easily and they can talk a lot, providing the homeopath with huge detail about their social, emotional and physical situation. For others, especially those who have been socialized into the orthodox medical way of recounting their illness-story, need to be prompted and directed more clearly as to the kind of depth and breadth of information required by the homeopath. Ultimately the patients retain control over the pace and extent of their

oral disclosure. Nonetheless, there may be things that from a homeopathic point of view are of interest, such as how words are delivered and appearance that the patient is unaware of.

At tutorials, tutors provide a largely supportive and supervisory role to the student-practitioners, giving advice on cases and facilitating discussion within the group. As it is an informal teaching environment, the tutor's self-presentation is much on a par with the students in terms of wearing smart/casual clothing, and sitting in a circle rather than at the front of a class. However, the tutors are still responsible for directing and moving on discussions in a facilitative way. Tutors are also required to provide ongoing assessment feedback to the college. This role as assessor is potentially in tension with the role as supporter, particularly because at the College of Homeopathy students are encouraged to share and 'work through' their personal difficulties, which may reveal issues that are in conflict with their competency as a practitioner. Indeed, power comes in many guises, and the 'niceness' or supportiveness of the tutors may mean that students, should they want to, find it even harder to resist this imperative to reveal aspects of their personal experience, or question its validity (cf. Belenky et al., 1997: 207-8).

In the student clinic, during the consultation, the body of the tutor, like that of the student observers, must be made as unobtrusive as possible, so as not to unnecessarily disrupt the dynamics of the patient-practitioner interaction. The group of observers are required to silence their bodies as much as possible as they watch, avoiding rustling papers, making noises such as coughing, or sudden movements. However, their embodied presence is part of the patient's experience and the observers are expected to be 'active listeners' contributing to 'holding the space' for the patients. Nonetheless, it is only once the student-practitioner has finished taking

the case, that the embodied presence of the observers are made explicitly socially visible again, by being asked if they want to contribute questions. Once the patient has left, the tutor's remit is to ensure that students do not go the 'wrong way' in their analysis, although the tutor may adopt a more directive role in the analysis of the case, especially if the student-practitioner is less experienced or less confident. Tutors also have responsibility to manage the class dynamics, ensuring that particularly vocal or bossy students do not dominate in case analysis. Through the role in managing the construction of the 'body-story' (as described in Chapter Five) of the patient, the tutor has the power to shape the students' development of habits of analysis, and the assignment of 'homeopathic' meanings to symptoms and stories. In addition, as with the osteopaths, the way that the experienced homeopathic teachers manage their own embodiment is influential for the students, who may respect them and seek to emulate them to some degree.

The tutors also have to provide reports on the students' attendance and progress to the college and this forms part of the decision about whether a student graduates. Therefore, students must adopt and demonstrate their ability to analyse cases as required. The responsibility of the tutor is to balance the learning requirements of students with the therapeutic needs of the patient. This latter requirement is particularly apposite, because the student clinics often take place in the same location as the tutor's own private practice so his or her reputation is heavily implicated.

Student-homeopaths must both negotiate their own learning and ensure that the patients are getting safe and effective treatment. In the tutorials, because of the flexible and informal format, students are able to be pro-active in choosing whether to bring cases for supervision, other topics for discussion, or to listen and learn from

others' experiences. In the student clinics, during a consultation they perform one of two roles: student-practitioner or student-observer. Students share out the responsibility for patients, so most will perform both roles during a student clinic day. The student-practitioner's body is subject to the scrutiny of the observers. His or her ability to 'be a homeopath' is being observed, in terms of embodied self-management and relational interaction with the patient. The homeopaths do not wear white coats, stethoscopes or any other markers of their profession, so it is through bodily deportment, interaction and the use of tools, such as the Repetory and Materia Medica, that the homeopath is able to define his or her role as professional healthcare practitioner.

The student-homeopaths actively produce and develop their own unique professional way-of-being during their interactions with patients (both observed at student clinics, and unobserved). They are able to select preferences for tutorial groups and student clinics to ensure that they find supervisors who they have a good relationship with, although they are strongly encouraged to get experiences of different tutors' ways of working. Their ability to negotiate and shape their learning experience is, however, curtailed by the requirement to meet the 'standards' imposed for case study reports.

The micro-politics of the homeopathy student clinic are, like the osteopathy one, clearly bound up with issues of embodiment and interaction. The complexity of the different embodied power relations that the students are part of in both learning contexts, tutorials and student clinic, influence the way that they manage their early forays into real patient case management. These different power relationships are inseparable from the *production* of an embodied homeopathic identity, or 'habitus'.

Building on the experiences of developing practitioner skills in the classroom and Live Case Taking sessions, the students learn how to manage ‘real’ patients both in student clinics, and outside of the college environment, but with the option of supervision in tutorials. Mediated by the power-imbued embodied interactions that these consultations and case analyses create, the students both develop the ability to competently practise homeopathy and produce an embodied ‘homeopath’ identity. In a similar way to the analysis of the osteopaths, in order for it to be possible to conceptualize the outcomes of practical training as the development of a ‘homeopathic habitus’, and to establish the nature of that habitus, it is necessary to explore both the unique habits of thought and action that the student-practitioner develops and the management of his or her own body in relation to the other participants. By examining the tension in the consultation between the roles of ‘witness’ and ‘educator’; the tension in the analysis between utilizing homeopathic expertise and ‘being appropriate’ to the patient, and giving consideration to the student’s management of their own bodies, the nature and complexity of the ‘homeopathic habitus’ produced will be explored.

The development of appropriate skills in ‘listening to body-talk’ (as described in Chapter Five) is mediated by the power relations described above in the clinical environment. Students must develop competence and confidence, especially because on graduation they are likely to practise independently. Tutors at the College of Homeopathy must be satisfied that the graduate homeopath is capable of not only practising safely and effectively in this way, but of being committed to continuing personal and professional development. There is a great deal of consistency between

the ideals espoused in the clinical environment and the classroom, perhaps largely because many of the clinical tutors also teach in the classroom. In addition, because the style of classroom teaching encourages ‘real’ interactions as much as possible, as opposed to role-play or other forms of decontextualized analysis and treatment, it is more congruous with real patient encounters.

Nevertheless, there seems to be an inherent tension in the appropriate role that the student-homeopath should play in the consultation. As opposed to the ‘detective’ role of the osteopath, aiming to get beneath the symptoms to the ‘real’ causes of the problem, the homeopath is supposed, as discussed in Chapter Five, to be a ‘witness’ to the body-talk of the patient, and match or mirror that body-talk through empathetic listening and the ‘similar’ remedy. Yet, on the other hand, the homeopath may also have to ‘educate’ the patient in order that s/he is able to produce accounts of his or her physical and emotional state that are appropriate for the homeopathic consultation.

As noted in Chapter Five, there is no ‘recipe’ for taking a homeopathic case. Indeed, all the cases I observed were very different, depending on both the ‘presenting complaint’, particularly whether it was primarily physical or emotional, and on the personality of the patient. However, in practice students often had to encourage the patient to reveal more detail about a symptom or condition, for instance, its physical, mental, emotional, environmental and social origins, its concomitants and the effect of the symptom on the patient’s life. Often patients who have never visited a homeopath before and have only ever experienced a GP consultation (which is much shorter and more focused on diagnosis), need to be encouraged to talk, and ‘educated’ into what homeopathy is and what kind of information a homeopath requires to prescribe. For instance, the homeopath might need to open out the discussion by

asking a question such as ‘What was going on in your life generally around the time that the symptoms started?’ One clinic tutor advised,

It is important to explain why you need the information. Say something like, ‘In order to prescribe I need to build up a picture of you as a person as well as your physical complaints,’ and that should help.

In this way, we can see that part of the power of a homeopathic practitioner habitus is to produce an embodied patient that talks. This kind of discussion and advice also serves to distance and distinguish homeopathic practice from orthodox medical practice in the minds of the students.

A number of students experienced difficulties if their patient would not readily talk or, at least, it was a source of worry for them. Some managed this worry by creating and bringing to the consultation a list of possible areas to question the patient on, such as parts of the body, ways of dealing with different emotions (such as fear, anger or anxiety), medication, daily pattern of energy, food likes and dislikes, appetite and effect of missing a meal, temperature (‘Are you a hot or a cold person generally?’ ‘... and when you are ill does it change?’), birth experience, accidents or operations, and family medical history. This latter question can often lead into discussions about relationships with family members and family dynamics, which can provide a richer picture of the patient’s social roles and the roots of their emotional responses.

However, one tutor warned, ‘I do not allow students in my clinic to just follow a set list of questions. That is not homeopathy. You have to be appropriate to the patient’.

In terms of analysis too, there was a tension between ‘being appropriate’ to the patient, and utilizing unique homeopathic expertise. Part of what the homeopath offers the patient is the ‘safe space’ to ‘witness’ the patient’s experience, rather than

imposing his or her own interpretations onto the patient. Yet homeopaths have a unique perspective on the meaning of health and the interpretation of illness, that they privilege in relation to other perspectives, particularly ‘allopathic’ ones. Most students come to homeopathic training already committed to some extent to homeopathy, and this commitment is deepened through repeated reinforcement and elaboration of this perspective in college (although outside of college student homeopaths often have to deal with sceptics and so develop strategies for doing this over time). Homeopaths often make assumptions that patients ‘can’t see what is really going on’ or are not ‘on the same level as us’, yet the message, repeated again and again in the College, is ‘you have to respond to where the patient is at *now*’ and ‘respond to what they ask for’. Similarly, they are encouraged to ‘educate’ patients about homeopathy and the homeopathic model of listening to the body-talk. If the patient refuses or ‘is not yet able’ to see those connections, however, they are told that they should not push them. Therefore, although the patient’s interpretation may be seen as less advanced than the homeopath’s, the homeopath’s interpretation is theoretically subordinated to the patient’s in terms of how to prescribe.

Evidently a balance needs to be struck, and the homeopath has special responsibilities which mean s/he can not abandon him or herself to the patient’s perspective (cf. Belenky et al., 1997: 227). The key skills that the students learn, in order to construct a homeopathic body-story (and match it to a homeopathic remedy), include the generation of time-sensitive (narrative-style) analysis and repertorization. The ‘theory’ of these skills has been discussed in Chapter Five, and the kind of information that the homeopath needs is discussed above. In order for the student-homeopath to be able to demonstrate his or her ability at case analysis and management, s/he must submit case studies. As we have seen in Chapter Four,

emotional, intuitive and reflective skills are highly valued in the College of Homeopathy. Interestingly, the assessment of case studies is one of the few areas of the curriculum that requires that students demonstrate more conventionally academic skills of analysis and report writing. Although students are encouraged to explore their relationship to remedies, ‘feeling a resonance with a remedy’ or ‘intuitively’ feeling a remedy is the right choice is not enough to pass case studies. The language of intuitive knowledge does not sit easily within an academic context.

I will now turn to the different aspects of analysis that the student-homeopaths are required to demonstrate competence in, and examine the ways in which the development of these skills contributes to the production of a homeopathic habitus. The analysis of the progress of a follow-up patient involves considering both the patient’s interpretation of the effect of the remedies and the homeopath’s own interpretations. Treating real patients rarely produces cure as simply as in ‘theory’. One tutor advised, ‘You need to look for a change in vitality in follow-up consultations, whether that is more, less or just different’. The homeopath may also have to educate the patient about how it is possible to interpret his or her changes in the light of the homeopathic healing process (as opposed to the biomedical model). This both reflects the homeopath’s power to define the healing process, and reflects the patient’s power to withdraw his or her custom from the homeopath at any time if s/he is not satisfied.

Homeopathic models of healing include Hering’s Law, part of which suggests that if symptoms have moved from a more ‘internal’ organ to an ‘external’ one then there is progress towards cure (such as from a kidney infection to a skin condition), which may seem distressing to a homeopathically uneducated patient. In addition, progress is not measured solely in terms of physical changes; just as social and

emotional factors contributed to the body-story, they can be affected by treatment.

One tutor explained,

Sometimes we give remedies and people wake up and get awareness and change... and sometimes they don't... Change can happen instantly with homeopathic remedies, but often assessment of remedy reaction is about life stuff, and physical symptoms are only a part of that... It is very dependent on the patient.

Homeopaths argue that the physical body is often slower to respond to treatment than the emotional body, especially in chronic conditions. Patients often report feeling 'better in themselves' before they notice significant physical improvements.

On the basis of what was revealed in the consultation the student-practitioners and the tutor discuss what needs to be healed: 'What are the key things that need to move forward for this patient?' The students are encouraged to listen carefully to what the patient's priorities are, especially what their presenting complaint is; as one tutor put it, 'because if you don't help their eczema or whatever, then they aren't going to come back.' However, the students are encouraged to be aware that sometimes a patient may come for a physical complaint 'because that is seen as an acceptable thing to visit a doctor for', but then spend the majority of the consultation talking about something else so this might be the priority for the homeopaths to respond to. The student-homeopath must learn how to negotiate the differences between the presentation of a 'medical' or 'homeopathic' patient, and to educate the patient into a homeopathic model.

Once again the dictum of 'being appropriate' is reinforced. The social context of the homeopathic encounter makes this a necessary skill for neophyte homeopaths to develop. Ultimately, the patient holds the final power of withdrawal from

treatment as homeopathy is practised largely in the private sphere. Therefore, the homeopath must do work to validate her or his professional abilities so that the patient feels that s/he is getting value for money from the treatment. In order to do this, the homeopath cannot, for instance, in a first appointment, be trying to convince a patient of a spiritual component to their disease if the patient has just revealed that s/he is an atheist. In this way, the patient and the practitioner must arrive at a body-story that makes sense in the patient's life-world, and the practitioner must match that story to a remedy.

The selection of the methodology for the case is another means by which the homeopath can negotiate the tension between 'being appropriate' and deploying his or her expert knowledge and skills. For instance, through the selection of the 'layers' methodology, the homeopath can treat whatever the patient's various forms of body-talk are saying most loudly and clearly, whether that be a life-threatening illness, or grief, or depression, while still maintaining the belief that there may be a deeper explanation for the problems. Simply described, the layer theory suggests that various events (physical, mental, emotional, social, environmental and spiritual) in a person's life create layers of pathology (in the widest sense), and that a very effective way to treat someone is to peel off the layers 'like an onion' to reveal the next layer, and so on until you reach the 'core'.

In the choice of remedy or group of remedies to give the patient, the student-homeopaths must demonstrate their skills in remedy selection and remedy differentiation. The students must learn repertory skills, become familiar with their remedies and learn to match body-stories to remedy-stories with as little 'translation' as possible. The clinics and tutorials provide an environment for students to rehearse

that thinking process, with the supervision of a tutor. The following examples show edited extracts from discussions of the process of remedy differentiation:

Anxiety is such a common symptom, so we need to look at the cause. Arsenicum will be anxious about their health and their family's, Argent Nit. about future events especially exams or public speaking.

Both Natrum Mur. and Staphysagria have a closed heart, but the reason Nat. Mur. is shut down is from grief, Staph. is emotionally unstable and scared of what might happen if they open up. Nat. Mur. intellectualizes their emotions, and may appear cool and distant, they are reserved and sensitive to criticism, they are often sad but unable to weep. Whereas Staph. are very nice, sweet people, but they are suppressed and unable to stand up for themselves. They have suppressed their anger, so confrontation is very difficult or they feel guilty or ashamed instead of anger, often they have suffered abuse from someone in power.

Once a remedy is selected, the students select a potency to administer it at. Again they must 'be appropriate': to direct the discussion, the tutors ask question such as, 'Energetically, where is the patient?' or 'What are you *intending* the remedies to do?' A final interpretation of the apparent tension between 'being appropriate' and using expertise, relates to how the remedies are believed to work, and disintegrates the tension. The remedies are 'little balls of awareness' or 'energetic mirrors' for the patients, which 'reminds' the body of what it is trying to do, and catalyses the healing process. For this reason, if the body (in its widest sense) does not recognize the reflection in the remedy at that time, then it will have no effect, so the expert practitioner must be 'appropriate' to the patient both in time and space.

Familiar with homeopathic consultations and the intimacy they generated, when I first heard about the arrangement for the student clinics I was very sceptical

about the extent to which it was possible to achieve an effective consultation in this way. So I decided it would be important to be a participant-observer both ‘as a student’ in the clinics and ‘as a patient’. I was surprised at the level of intimacy that it was possible to achieve in the room. As a patient, I found that at times I practically forgot that there were other people in the room, and as a student, I was impressed at the focus that the students were able to give to the patients they treated. As a ‘patient’, I asked whether it was possible to be present during the discussion and analysis of the case. The tutor was very happy for me to do this and, in fact, although the first time it happened the students commented that it was odd having the ‘patient’ present, the tutor said:

This is really good experience for you... it is what you have to do when you are actually practising and you have to talk through your prescription when the patient is with you... that is what you are going to do eventually... you’ll have to convince the patient of your prescription by talking it through with them. That is the first stage of healing... it also reminds you not to make assumptions about the patient as you have to focus only on what has been said.

Later in this consultation, the student-practitioner decided that the remedy ‘Thuja’ matched my body-story well. I was quite perturbed by this, as I did not feel that I fit that picture, as in my limited understanding I had quite a negative perspective on the remedy. The student justified her decision and painted a wider picture of the remedy than I knew about and I became satisfied that it was a good prescription. The tutor said, ‘This is another great learning experience, because if Nicola had just gone away and we’d sent her Thuja she might have been unhappy, or even not taken the remedy, and this is something to consider for patients. It is so important to share with them

your interpretation of them and the remedy and check that they are happy and know what you are trying to do.'

I now turn to a closer examination of the 'body' of the student-homeopath. In order for the student-homeopaths to be able to fulfil their role as 'witness' and to 'be appropriate' in the analysis of the patient's case, they must pay attention to their own embodiment. They must be able to achieve an intimate empathetic connection with the patient, while maintaining appropriate professional boundaries, and they must be able to manage their own emotions and experiences through reflective practice. In addition, they must produce embodied distinctions between their skills and those of other healthcare practitioners, particularly orthodox medics.

A notable absence in clinical (or classroom) environment for the student homeopaths was any discussion of what might be suitable professional clothing. There may be a number of explanations for this: firstly, very few homeopaths use white coats (although some medically qualified homeopaths do). Secondly, homeopathy treatment does not include any touch-based treatment and so there is no need for patients to remove clothing or for that kind of physical barrier to be in place. Thirdly, the nature of the homeopathy consultations is intimate and individual, so the white coat may not be seen as an appropriate social barrier to construct in the consultation. Fourthly, the College is committed to giving students the space to develop their own style and ways of practising and so a 'school uniform' rule would be inimical to this aim¹⁶. Lastly, homeopaths often position themselves in contrast to, what they perceive as the inadequacies of the biomedical model, and so not wearing a white coat would distance them from the orthodox profession in terms of their

¹⁶ Some other homeopathy colleges do require their students to wear white coats in student clinics, so this college was not necessarily representative.

embodied self-presentation. It is, however, difficult to draw firm conclusions about these reasons because clothing was never raised as an issue in the educational context.

The development of the homeopathic habitus, then, relies on other ways of producing distinction and boundaries from other bodies, in particular, emotion work, and reflexivity. In order to be able to accurately select a 'similar' remedy, the patient must be able to imaginatively construct the client's body-story, while ensuring that they keep their own prejudices and sensitivities separate (cf. Hardesty, 1986: 252). In order to do this, they must both be self-aware and able to create effective boundaries. The homeopaths rarely used the term objectivity but often used 'awareness' to describe a similar practical process. The founder of homeopathy, Hahnemann, suggested that the homeopath should be an 'unprejudiced observer' so that s/he can identify the correct remedy to match the patient in a scientific manner. However, like any profession, homeopathy is constantly developing as new practitioners offer reinterpretations, and the college encourages reflective practice. As one of the college's founders put it,

The homeopaths of the future will not be 'unprejudiced observers'. They will be self-aware participants in the magical interaction that occurs between practitioner, patient and remedy (college prospectus).

The feedback and reflective discussion in the clinical training environment provides a forum for students to develop these skills, not least because the tutor and the other students, in their roles as 'observers', can make the student aware if s/he is 'reading too much' into what the patient says, and open it up for discussion.

In one example, the tutor asked the student why, when the patient had started to cry (for the first time in the consultation) did the student immediately offer the

patient tissues. Because the students are encouraged to ‘hold the space’ for emotional expression and not try to curtail it, so the student’s actions were a bit of a homeopathic ‘faux-pas’ in this context. The student responded,

Yes, I don’t really understand why I did that, I’ve never done it before, as I handed the box of tissues over I thought ‘why am I doing this?’ but later on when [the patient] started to cry again I didn’t do it again.

The discussion that followed explored the possibilities for the action of handing over the tissues, including whether the student herself was uncomfortable with the issue that had made the patient cry, or whether she sensed that the patient had ‘more to say before the tears were ready to flow’. In the end, they agreed that it was impossible to reach a definite conclusion, but that it was important to maintain an ‘awareness’ of the issue for the future.

One tutor advised, ‘Unless you can separate out that stuff it’ll be very hard for you to be a homeopath.’ In order to become ‘aware’ of their ‘own stuff’ the students must ‘work’ on it. A tutor commented that the College provided the students primarily with a ‘safe place to transform and grow’. Students are also required to see a homeopath themselves during their training, to maintain and protect their own health, and to deal with any physical or emotional problems that arise for them. One tutor explained, ‘If you find you have a strong reaction, especially dislike or irritation, to a patient, think about what it brings up for you... If you can be honest about that it usually goes away.’ The tutorials provide a particularly good environment for general discussion about the management of personal boundaries. For example, one student raised in a tutorial her concerns that she had about feeling an overwhelming sense of responsibility for the outcome of the people that she was treating. She was concerned

that this went beyond a reasonable level of concern about doing a good job. Part of the problem, she found, was that as a student she was often treating friends. The student recounted one particular situation that she had found particularly difficult where she talking to a friend about a history of abuse and had prescribed a remedy for the friend. The tutor said, 'It sounds like you need a remedy too,' and the student responded 'Yes I probably do but which one?' The tutor suggested that the student take a dose of Carcinodin 10M which is a miasmatic remedy often given to people who have too much responsibility, often from a very young age, and who find it painful to let people down in even the smallest ways. This example highlights the precariousness of the students' position as not-quite a qualified practitioner. Most students source their early patients from within a circle of friends and family and this compounds the strains on the patient-practitioner 'dialectic of distance and intimacy'.

To help manage their boundaries, the students are encouraged to do their job of matching the remedy to the patient's body story, but then 'give the remedy without expectation' or, in another tutor's words, maintain 'non-attachment to the outcome'. This is couched in terms of avoiding 'rescuing' people, because rescuing, one tutor said, 'is about the practitioner's needs not the patients'. Providing the 'energetic mirror' of the remedy is the role of the practitioner, and as one tutor says, 'That is all you should do, what they [their vital force/ body] do with the remedy is up to them.' Another said, 'You have to remember that the patient is the only one that can heal themselves.' This is seen by the homeopaths to have two implications, firstly, it protects against abuse of the practitioner's power because you cannot force someone to change in a way that you see as desirable with the remedies. They are not material substances (drugs) but 'energy medicine', and as a practitioner you can only stimulate the body's awareness and capability for transformation. Tutors say things such as

‘remedies are invitations for change’. Secondly, that you should prescribe with humility, because ‘your remedies are only one possible way that the patient can initiate transformation in their lives.’

Through the examination of one detailed example of a case presentation, I will explore the ways in which, in tutorials, the flexible inclusion of discussions on reflective practice, case analysis, homeopathic theory and personal development affects the habits and ways of listening to their own and others bodies that the neophyte homeopath develops. The student introduces the case by saying, ‘I was really pleased, it is a clear aetiology case, which was so nice to see.’ The patient was a woman in her early 60s, who had had a road traffic accident two years ago. She was now suffering from anticipatory fear about travelling of any type, which was affecting her relationships because she was becoming so nervous about her family, especially her husband, driving her anywhere. In addition, she was worried that she could not be spontaneous anymore, because she felt that she had to plan every journey very carefully just to alleviate the fear a little. The student then described her observations of the woman as ‘a lovely person, gentle, who does yoga, very calming and concerned to help people.’ She went on to explain the case further, and said that she had written down a few verbatim quotes from the patient because they were illuminating. At this point the tutor validated this with, ‘It is good to write down direct quotes, because then it is the patient’s language, not your own which can sometimes distort things.’ This reinforces the idea that there should be minimal translation of the body-talk in case analysis. The student continued to report the expressions that the woman used, such as she felt ‘the sensation of my stomach churning’, ‘agitation’, and a ‘screaming in the head’. The woman said she felt ‘disappointed in myself for not being able to stop these feelings’. The student said that she had repeterized the case and come up

with the remedy Argent Nit. to be taken at the 1M potency split dose, repeated three days apart.

This case sparked a number of lines of discussion – about methodology, about the use of the repertory, about potency, and about the experience of case-taking and intuition. The informality of the class allowed for the intermingling of issues, as there was no strict agenda. The tutor pointed out that the student seemed to have confused her methodologies. Having begun by saying that it was an Aetiological case, and that all the symptoms started from that point, she had in fact done a more Constitutional prescription by repertorizing the patient's current mental, emotional and symptom picture to arrive at Argent Nit. The student then commented that while taking the case she had written a couple of times in the margin 'Opium 10M' to deal with the experience of shock at the time of the accident, but then had (unintentionally) disregarded that in the final prescription. She felt that she had not 'listened to her intuition' about the case, or at least given it enough consideration as a possible prescription. The tutor pointed out that the Argent Nit. had been a good prescription because it has fitted the current picture very well, and that it had been a 'good learning experience' for the student 'at many levels'. It had given her the opportunity to spend time familiarizing herself with the repertory and enabled her to evaluate what her relationship was to her intuition. The tutor suggested that the student write about this case and her experience in her learning journal. The student was then really concerned about how she would write up the case because she felt she had done the wrong thing. The tutor and another student reassured her that it wasn't the wrong thing, it was just a different approach to the case. The tutor said that in presenting cases for assessment, 'It is all a question of argument. There is not one answer'.

The discussion turned to how it was possible to repertorize an aetiology case, and that sometimes appropriate rubrics were difficult to find. Often they were expressed as ‘SHOCK [or whatever the event was], ailments from’. A student suggested that if the patient remembered then you could repertorize their symptoms at the time of the event. There was also a discussion about potency, and suggestions that if the NBWS (never been well since) event was a long way in the past, that a higher potency would probably be needed because the event was ‘hanging around in the ether, not at a really immediate physical level’.

It can be seen here that the initial case presentation turned to a discussion of the student-practitioner’s own personal and professional development, a specific and then a general discussion about the difference between prescribing aetiologically and constitutionally, and about ‘playing the game’ in producing assessed case-studies. In this example, like for the osteopathy students, analysis of the case is not done in partnership with the patient. The students must learn repertory skills, become familiar with their remedies and learn to match body-stories to remedy-stories with as little ‘translation’ as possible. However, the educational environment requires that tutors are able to question and challenge students on their choices, their theories and methodologies and their abilities to be reflective about their practice and their responses to the patients.

Ultimately, the production of ‘the homeopath’ is bound up in the complexity of the interactions and deployment of knowledge in the patient-practitioner encounter. Through the requirement for students to submit case studies for assessment and the ongoing assessment in the clinics and tutorials, the college is able to define the knowledge and skills that the student must develop in order to graduate. However, this is tempered by the emphasis on self-development, which must be tailored to the

individual, and on the fact that the skills that students must use in practice are, to a large extent, dependent on the patient who is sitting in front of them.

Conclusion

In both colleges, to be considered a ‘good’ osteopath or homeopath requires some mastery of the received knowledge in the profession, whether that be anatomy or remedy pictures. In the College of Osteopathy particularly this component is very heavily assessed and held up as ‘proof’ of the graduating osteopath’s competence. However, the development of embodied, intuitive and emotional skills is also valued, particularly in the clinical context.

The clinical experience is deeply imbued with embodied power relations, that contribute to the ‘production’ of the bodies of the osteopath and homeopath. Within the educational environment, the student’s lack of knowledge (e.g. familiarity with remedies, diagnoses) and their need to explicitly reflect on and receive feedback on their performance precludes the more genuine *exchange* in developing body-stories that a more experienced practitioner might have the confidence to do with patients. Potentially this separation of the analysis of the body-talk in developing a viable body-story to work with in the student’s training could have a long-term impact on the power relations that dominate their future practice. While expertise in patient-practitioner interaction and treatment is seen as something that develops gradually and continues throughout the osteopath’s or homeopath’s career, the colleges exercise their responsibility to ensure that students reach a ‘safe’ and ‘effective’ standard of practice before they graduate through supervision of students in practice.

The production of a ‘homeopathic habitus’ or an ‘osteopathic habitus’ is bound up in the embodied power relations of the clinical experience, and has been explored in relation to the development of habits of thought and analysis and the students’ management of their own embodiment at many levels.

Discussion and Conclusions

To draw together the different threads of discussion in this thesis, I will reflect back on the study, considering its contributions, methodologically, empirically and theoretically. Drawing on debates and questions raised in Chapter One, I will consider how ethnographic research on the training of osteopaths and homeopaths has contributed to our understanding of the nature of healthcare knowledge and practice, the power relations in patient-practitioner relationships and the nature of the process by which students become competent professional practitioners. In the light of this discussion, I will assess the implications of the thesis for policy and practice, and identify potentially fruitful areas for future study.

Methodology

Turning first to the issues of methods and methodology. Ethnographic research provided two key benefits for this study: understanding from within and deeper embodied insights into the setting. The central research method in ethnography is participant-observation, which is rightly valued because it enables the researcher to immerse herself in the setting and gain an understanding of the nature of the social field that mediates the experience of its participants. As I noted in Chapter Two, this can be particularly valuable in sub-communities that are in some ways in conflict with dominant culture. Becoming immersed in an-‘other’ community does, of course,

carry with it certain risks for the researcher, such as the classic anthropological problem of ‘going native’, but with an ongoing motivation for academic research and through the disciplined application of reflexivity-in-practice this risk can be forestalled. Understanding a community, such as a CAM profession, ‘from within’, while also applying the sociological imagination or gaze to the data collected, has multiple benefits. It ensures a high degree of validity in the findings, as they are made on the basis of triangulation between detailed observation of the social field and the participants *in situ*; interaction, informal interviewing and discussion with the participants, and personal participation in the setting. This kind of research also has great applicability in terms of policy and practice, because, coming ‘from within’, it raises issues that are relevant to those who seek to make improvements to practitioner training and to regulate the profession.

Participation in the research setting also permits deeper embodied insights into the experience of learning, and the nature of osteopathic and homeopathic ways of knowing. Learning ‘alongside’ the students resulted in changes in my own habits of thought and perception (and to a lesser degree action, as I was not aiming to be a practitioner) that, through rigorous reflection and sociological analysis, I was able to capture and verbalize. It was not only the students who developed new ways of knowing the body and embodying knowledge, but I did as well. Finally, writing the ethnography allowed me to preserve some of the internal integrity of the setting, while also analysing the data to answer questions raised in Chapter One. These questions included both empirical issues about the practice of CAM therapies (their knowledge base, the deployment of embodied power and the development of professional identity) and the training of their practitioners, and theoretical issues

about the importance of considering embodiment in healthcare practice and education in particular, and sociological analysis in general.

Obviously, there were some limitations to the study. In particular, the selection of the two case studies may have exaggerated the differences between the two professions, as I chose a particularly esoteric homeopathy college to study and an osteopathy college that had chosen to adopt a highly integrative relationship with orthodox medicine. In addition, even within the two colleges my time was not distributed evenly between all the students because I conducted participant-observation with specific classes to follow their progress. I feel that the depth of the data collected compensates for any lack of breadth, and offers the best opportunities for understanding the embodied experience and process of learning to be a practitioner.

Knowing the Body

It has been possible, through research on the training of osteopaths and homeopaths to contribute to sociological understanding of the play of power, knowledge and the body in these healthcare practices. The educational environment provides a unique setting for enhancing our understanding because of its explicit focus on the students and their development of relevant knowledge and skills. In particular, I have argued that it is essential to consider the role of embodiment in learning to be a healthcare practitioner. The subject of professional knowledge is not only the body of the patient, although clearly an understanding of how the body functions in health and illness is crucial. There is another body in the therapeutic encounter – that of the practitioner – which is heavily implicated in the healing process. Indeed, it is through

the interaction between these bodies that healing is produced. Student practitioners, then, must learn to turn their attention inwards and to reflect on the ways in which their own embodied characteristics impact on this interaction.

This thesis has given us greater understanding of the nature of the body in osteopathic and homeopathic practice and philosophy. In neither therapy is the body considered to be a passive ‘machine’, liable to malfunction, and subject to the will of the practitioner. The body is understood holistically, as the interplay between physical states, mental states, emotions and the environment. It is fundamentally self-healing, but can experience stasis (osteopathy) or a deficit in vital energy (homeopathy). When ill-at-ease the body is expressive (it ‘talks’) and this body-talk can be listened to by the attentive practitioner, through the development of embodied skills in case-taking, observation and palpatory or energetic touch.

In the osteopathic consultation, the practitioner must identify how the body has become ‘stuck’ and try to restore movement and flow. By bringing the physical body back into alignment and full function, the other parts of the body – the mental and emotional – follow as all are fundamentally interconnected. In the homeopathic consultation, the practitioner aims to identify the fullest picture of the origins and development of the current expression of dis-ease. Symptoms in homeopathy are understood to be the body’s attempt at self-healing. By reflecting this information back to the patient through the prescription of a similar remedy, and by creating a ‘safe space’ for the patient to develop new awareness of the connection between symptoms, the healing process is catalysed. Body-stories, in the clinical context, are co-produced. ‘Raw’ experience is translated in the talking/listening process in order to produce a story, both by the patient and by the practitioner who records it (however

accurately) in his or her notes. It is shaped by the context of its production and the interaction in the patient-practitioner relationship.

As the thesis has shown, the basis of knowledge claims in the therapies is vital to consider, especially the value assigned to different perspectives in the clinical encounter that this implies. For instance, in osteopathy, certainly as it was taught at the case-study college, there remains a clear distinction between the ‘symptoms’ reported by the patient, and ‘signs’ observed by the osteopath, with tutors often referring to the latter as more ‘objective’. The osteopaths were more likely to define patients’ experience in terms outside of the patients’ own understanding, using osteopathic terminology.

The homeopaths, by contrast, rarely talk about ‘objectivity’, relying instead on learning to get as much detailed body-talk from the patient as possible. While, undoubtedly, homeopaths sometimes felt that they were able to see ‘deeper’ connections between symptoms or reasons for symptoms, it was repeatedly stressed to students that they should not make assumptions, but ‘be appropriate’. Unless the patient had brought an issue up in the consultation, the students could not use it as a basis for prescription. In this way patients retained a degree of control over the amount of information that the homeopath could have about them and, therefore, use. Nonetheless, the homeopaths do learn to try and ‘produce’ a patient that has greater awareness of his or her own issues and is able to talk about them. Clearly, the play of embodied power is complex in the homeopathic consultation.

The patient-practitioner relationship is mediated by the institutional set up and embodied power relations. In the educational environment, which was the subject of this research, the already culturally and socially bound patient-practitioner relationship was made more complex by the dual goals of the student clinics: to help

heal patients and to educate practitioners. In order to manage the tension between these two goals, much of the analysis of the patient's case takes place without the patient present, which served to reproduce active-passive roles during much of the consultation. However, this arrangement was also vital to provide students with the opportunity to learn to 'think' and 'reflect' in an osteopathic/homeopathic way. The repetition of the analysis process, the observation of experienced practitioners, and the careful reflective analysis contributed to the students' acquisition of embodied skills and competence. Students were able to learn how to negotiate their role and responsibilities in the consultation and the healing process in general.

Embodying Knowledge

By taking an embodied sociological research approach to the question of developing professional knowledge, skills and identity, this thesis has been able to offer a richer and more nuanced account of the learning experience than those offered by analyses of 'professional socialization'. Although 'professional socialization' usefully explores the idea that students adopt the knowledge, skills and values of their chosen profession, as a theoretical model it fails to adequately explore the resistance that students can demonstrate, the diversity and debate within professions which new students are able to contribute to, or the actual embodied changes that students experience (which are potentially capable of 'spilling' over into other areas of their lives, such as the personal, social and financial). My research reinforces these critiques and offers additional empirical insights into the embodied aspects of professional training in osteopathy and homeopathy.

In Chapter Three, the importance of the balance between academic and practical knowledge was stressed. Both the historical development of the professions and the political issues that they face today can be seen to contribute to the content and structure of the courses. The focus of the learning experience in osteopathy and homeopathy was not only on the patient's body, but on the body of the practitioner as well. The construction of the curriculum demonstrated that while abstract knowledge, such as human anatomy or remedy pictures, was considered essential by the educators, practical clinical experience was also seen as fundamental to developing professional competence. For this reason, a large proportion of contact time was assigned to working with patients and the inclusion of classes on, for instance, Communication Skills (osteopathy) and Personal Practitioner Skills (homeopathy) demonstrated that these 'soft skills' were not taken for granted as merely natural skills.

In Chapter Four, students' responses to the curriculum structure, content and assessment were examined and analysed, demonstrating firstly, that students' did not unquestioningly accept what they were required to do or the values and opinions espoused by the tutors, and secondly, that they were able to 'play the game' to some extent, particularly the osteopathy students who talked of 'jumping through hoops' and recognized that they had to adapt their actions and thought processes for different assessments. This chapter demonstrated that the learning experience was not a passive one, that students constructed their own meanings about osteopathic and homeopathic practice through the lens of their own bodies, including their past experiences. Indeed, to some extent personal reflection was explicitly encouraged. Additionally, it demonstrated that the 'profession' that the students aspired to belong to was far from unified, and that students were able to adopt and resist different

perspectives within the profession in a critical way. Within the limitations of the course requirements and assessment that promoted certain forms of embodiment, students developed an individual style of practice.

In Chapter Five, the students' experience of learning the 'theory' about health and healing also placed their own bodies into central focus. Knowledge of the patient's body could only be obtained through interaction, and listening with ever increasing sensitivity to the language of the sick body or, what I termed, the body-talk. Although clearly there was a notion of 'received' knowledge in the professions, it had to be reproduced by each individual student at an embodied level, in order to become meaningful or useful in practice. In addition, the analysis and treatment of the patient had to be considered with more than a cursory nod to reflective practice. Being able to analyse and treat effectively was fundamentally bound up with skills in reflexivity, which involved, especially for the homeopathy students, a deep commitment to self-understanding and self-development.

In Chapter Six, there was an in-depth consideration of the process by which students learn to work with real patients in the clinic environment. I argued that it was possible, using a Bourdieusian framework, to understand the development of professional skills and identity as the production of a homeopathic or osteopathic habitus. I argued that it was the play of embodied power relations in the student clinic that produced and largely defined the 'competent' professional. Students were required to demonstrate certain skilful habits of thought, reflection and action, and were able to learn from interaction with tutors who offered a variety of embodied role models. The complexity of this learning environment had significant influence on the patient-practitioner relationship in the student clinic, specifically limiting the potential for a partnership model of interaction. At both colleges, there was diversity in the

attitudes, values and ways of practising that the tutors embodied and a recognition of the legitimacy of individual variation among practitioners.

By using Bourdieu's concepts of habitus and field and examining the embodied power relations in the educational field, a deeper understanding of the process of becoming a professional is possible. Learning for these students does not simply require adding new homeopathic or osteopathic facts to their virtual repertoire. Students learn a distinctive (homeopathic or osteopathic) form of embodiment, which includes new ways (eventually intuitive) of thinking and acting. Some of the ways of thinking and acting that they are exposed to may be apparently contradictory due to the diversity of approaches with the profession and the focus of different units or classes. The students negotiate the different approaches that they observe, and find out which they are most comfortable with. Learning, then, is not just about students assimilating knowledge, but about developing their own opinions and 'style' of practice, changing their ways of relating to others and understanding their own embodiment and identity. This research has shown that any model of learning needs to consider incorporating the personal and the social experiences of the students, as well as the 'body' of knowledge that they are interacting with.

By thinking of knowledge-in-practice being produced through the habitus, we can also glean useful insights into the play of doxa and symbolic violence in the wider social field of health care. Because students are encouraged to develop an 'individual style' (osteopathy) or their own relationship to remedies (homeopathy), 'external' validation of knowledge is not always assigned priority. The students' individual embodied experiences in relation to both others' and their own experiences of osteopathic or homeopathic healing enable the students to develop confidence in and commitment to healthcare practices that are not widely accepted. Students are then

able to resist the symbolic violence that de-values their profession's 'inferior' scientific foundations by producing local, contextualized, embodied validation. Although at the College of Osteopathy there have been some concessions to the imperative to justify the practice with biomedical teaching, the individual student's ability to practise safely, effectively and reflectively is the central requirement for graduation. At the College of Homeopathy, this local authorization (cf. Skeggs, 2004b: 25) is taken one step further so that a large proportion of the assessment of the course is self-appraisal, rather than independent evaluation.

The student's production of the homeopathic or osteopathic habitus involves the management of their bodies, in particular the negotiation of the boundaries between their own and others' bodies. It is clear that the breadth of information required by osteopathic and homeopathic practitioners is much greater than a GP requires and the time spent in (intimate) interaction with the patient is greater, which further implicates the practitioner's body in the healing process. This bodily management involves external bodily presentation, such as the wearing or not of white coats, but is also related to reflective practice. This is particularly clear at the College of Homeopathy where students learn that they must be able to distinguish in practice what is 'their stuff' from what is the 'patient's stuff', and must therefore demonstrate capability in and commitment to ongoing personal development. They must learn to listen to their own body-talk and devote themselves to ongoing self-awareness and self-healing as an integral part of professional capability. In a very real sense, they must 'embody' homeopathy.

This thesis also contributes to theoretical debates about the relevance of ‘the body’ or ‘embodiment’ to sociology. Paid work in any form is necessarily embodied (Wolkowitz, 2006), and in healthcare practice the bodies of practitioners are in interaction with the patients, making that embodiment clearly tangible. The added advantage of research looking at the training of healthcare practitioners is that the body of the practitioner is an explicit focus of the social environment giving access to the kinds of values and modes of embodiment that underpin day-to-day practice.

While experienced professionals have often come to take for granted their professional bodies, and may find it difficult to explicate what they are doing (Lawler, 1991), students are negotiating these new ways of being and interacting in the world for the first time, bringing the body (especially its ineptitude or clumsiness) into explicit focus. Thus, as a result of this research, I have been able to offer two contributions to embodied sociology: a clearer and deeper understanding of the nature of embodied knowledge and its re/production through the learning process, and a further elaboration of the theoretical limitations of mind-body dualism in sociology.

Embodied knowledge can only be acquired through embodied experience and practice. Developing embodied knowledge involves the body (in its widest sense) becoming accustomed to new ways of seeing, listening, feeling, doing, and, indeed, being. As Bourdieu describes the development of practical sense as being a ‘feel for the game’, so embodied knowledge involves an ability to perceive and act (practise) in ways that concord with the discipline in question (be that homeopathy, osteopathy or any other). In the learning environment, this embodied knowledge is developed and refined through repetition and embodied reflexivity. For the osteopaths, the

building of a 'palpatory library' enables the development of ever-greater perceptive sensitivity to the human body. Through touch and observation, the osteopath intuitively (without purposeful thought) knows what is wrong with the patient. For the homeopaths, it involves learning to be a witness to the patient and over time they quieten their own internal chatter through the development of skills in reflection-in-practice to focus on that witnessing. They learn to ask questions to educate and facilitate the individual patient's process of coming to awareness about his or her condition. These questions, although different every time, are purposeful and habit-driven, based on an embodied knowledge of the homeopathic healing process. They do not have to 'think', as this draws them back into their own world away from the witnessing; they just act through their homeopathic habitus.

Embodied knowledge is only made socially meaningful through interaction with others. It has no practical or social reality outside of the body because it is through practitioners' own sensuous experiences that they assign meaning to or 'get a feel for' the patient's body and how it may be healed. Nonetheless, embodied knowledge can be generalized verbally (at least to some extent) in order to define a socially meaningful and socially valuable skill. These words are not 'the knowledge' and may not capture everything about it, but the linguistic signifier serves a useful purpose, especially in the definition of necessary skills and knowledge for competent professional practice.

I would argue that an understanding of embodied knowledge is vital to a concept of professional 'expertise', because it is something that becomes subconscious, instantaneous and feels natural, as in Leder's (1990) 'absent' body. The development of intuition and expertise in healthcare practice is similar to what Tedlock, in her study of women in shamanism, describes as 'wisdom':

Knowledge consists of empirical information passed on from teacher to pupil. Wisdom adds to that an intuitive grasp of the complex connections and forms of consciousness in the natural world (Tedlock, 2005: 137).

Nonetheless, I would dispute her definition of knowledge as simply empirical information. The ‘passing on’ of knowledge is a fundamentally embodied process. It is for this reason that thinking about the learning process in healthcare practice as the development of a habitus is so useful. Bourdieu’s conceptual development of habitus has a great debt to phenomenology, as Crossley (2001) and Skeggs (2004a: 85) note, and it is particularly true on the issue of sub-conscious action,

The lived experience itself, and the objective moment constituted in it, may become ‘forgotten’; but for all this it in no way disappears without a trace; it has merely become latent. With regards to what has become constituted in it, it is *a possession in the form of a habitus*, ready at any time to be awakened anew by an active association (Husserl, 1972, emphasis in original, cited in Skeggs, 2004a: 85).

Finally, we can say that embodied knowledge is neither universal nor fixed. It is constantly being explored, enacted and shifted through everyday praxis. It is in a perpetual state of refinement or transformation and re/production. Indeed, it is likely that all human knowledge that is socially meaningful is embodied knowledge. For the students of homeopathy and osteopathy (although this could potentially be expanded to include all healthcare professions and forms of work), this means that while the object of professional knowledge is undoubtedly ‘the body’, it is only possible to develop that knowledge *through* the student’s own body. The centrality of the individual practitioner to the re/production of professional knowledge makes ethics a

vital consideration. The student must have an understanding of how his or her own embodiment (including health, sensitivities, prejudices) contributes to the deployment of professional knowledge and power. Reflexivity, then, is not an 'add-on' or a temporary measure in difficult situations, but a lifelong process that is fundamentally incorporated into the re/production of knowledge through practice. For educators, the student's development of reflective skills should be a primary concern. And for sociologists, this provides greater support for acknowledging the centrality of embodiment to our understanding of knowledge, power and social action.

Understanding knowledge as embodied also provides additional support for the rejection of mind-body dualism in sociology. Dualism creates serious theoretical limitations for the sociologist trying to understand social praxis, as many feminists and sociologists of embodiment have argued. In the field of learning and education, it is often helpful to talk about different forms of knowledge, such as academic or emotional knowledge. Indeed, concepts such as 'emotion work' have been vital for validating the work that, among others, mothers, nurses and other women (and some men) do. However, while at times in this thesis, I have used these terms and distinctions, I must make clear that these skills and ways of knowing are developed alongside each other and are interdependent. As the old idiom goes, 'The whole is greater than the sum of the parts.' For the osteopaths, while they learn academic anatomy which they can regurgitate in examinations, it is only through the utilization of those academic concepts in conjunction with repeated touch and exploration of the living body that they become relevant for practice and the students develop their skill in osteopathic palpation. Similarly, for the homeopaths, they can learn remedy pictures and symptoms, but it is only once they can sit and listen to a patient, creating a 'safe space' for that patient to relate his or her own story, that they develop their

skill in homeopathic prescribing. It may be the ability to ‘embody’ a particular way of perceiving and acting in the world that makes any profession distinctive.

Implications for Policy and Practice

At the centre of many debates about the future of CAM, particularly the regulation of professional groups, is the question of what constitutes legitimate knowledge about the body and the healing process. In contemporary Western society it is hard to overestimate the influence of medical knowledge on healthcare practice. For some CAM therapies, the inclusion of medical knowledge in the curriculum has been an integral part of the drive for legitimation. The discussion in Chapter Three about the structure, content and delivery of the curriculum elucidated the ways in which legitimate knowledge was constructed by educators.

At the College of Osteopathy, the large amount of biomedical knowledge included in the curriculum, and the examination of students on these ‘facts’, clearly shows a concession to cultural and regulatory imperatives that value reproducible scientific knowledge, the mastery of which can be independently evaluated. By contrast, at the College of Homeopathy, these imperatives have been resisted to a large extent. While the value of learning anatomy and physiology is not negated, ‘allopathic’, as it is often termed, knowledge about the nature of illness and the healing process is not considered fundamental to homeopathic practice. Specific biomedical diagnoses are only one type of information that the homeopath can work with, and they can prescribe on the basis of a picture of mental, emotional, physical, social and spiritual symptoms, even without a biomedical diagnosis.

Despite the inevitable discussion about whether the knowledge base of these practices is 'scientific' or not, it is clear that these professions do not seek their validation (only) from science. Indeed the emphasis in the case study courses on the development of practical knowledge and interactive skills demonstrates that individual 'experience' is considered essential to the development of professional competence. For both of these professions, as I would suspect is the case for any form of healing work, part of the essential knowledge of the practice, is the practitioner's understanding, awareness and familiarity with his or her own body, and an ability to be reflective about it in practice. This has fundamental implications for the development of training programmes and the creation of standards of knowledge and practice in regulatory processes.

Questions about how it is possible to 'teach', 'learn' and 'assess' embodied knowledge are central for the future of the professions. For example, current divisions in the homeopathy profession often centre around the question of whether biomedical knowledge is an important 'foundation' for homeopathic practitioners to have, and the work being done by CORH to create a single register of homeopaths is tackling these questions head on. If embodied knowledge is to a large extent unique to the individual, then the validity of teaching and assessing solely through abstract, reproducible knowledge is significantly undermined. In addition, the importance of reflective practice indicates the validity of stressing continuing personal development as a vital component of professional skills.

Apart from regulation, another key question in current policy and practice is the possibility of integration with orthodox medicine. The statutory regulation of osteopathy has generated a great deal of dissent within the profession. Not only has the requirement for a common language to work with required that osteopaths

adopt biomedical models and terminology, but the promotion of the role of osteopaths as ‘musculo-skeletal specialists’ (Baer, 1984: 720), as opposed to more general healthcare practitioners, has been strongly opposed by some within the profession, many of whom were taught in the ‘classical’ model of osteopathy. Although most homeopaths are prepared to consult and cooperate with GPs and to treat alongside orthodox medical treatment, the broad scope of homeopathy overlaps considerably with orthodox medicine, as virtually any condition can be helped with homeopathy. This generates massive tensions as the philosophical and practical approaches of homeopathy and ‘allopathy’ are largely contradictory. Nevertheless, it is important to promote understanding between different healthcare professions, and this thesis potentially contributes to that.

There is increasing emphasis in many healthcare professions on developing ‘holistic’ models of practice, and narrative-based medicine has been a key development in that process (e.g. Greenhalgh & Hurwitz, 1998). Frank (1995), Hyden (1997) and Kleinman (1988) have shown how illness narratives give the sufferer of the illness a valid reality (a voice) other than that which has been said about their disease within biomedicine. However, the ability to tell a story indicates some level of acceptance and processing of the experience, which is why writing is often considered to be therapeutic (e.g. Bolton, 1998). My research suggests that linguistic form may only be the ‘icing on the cake’ when it comes to illness stories (or indeed any embodied social experience). Memories that it is possible to articulate are not the only carriers of meaning about past experiences. As the discussion in Chapter Five shows the body is able to express dis-ease. Illness can be the result of events, feelings or experiences deeply suppressed with the individual’s consciousness, but written on the body, and capable of being brought into awareness (see Lee, 2001 for a personal

account of this process of uncovering the origins of illness). The body then is also an actor in this process, so the concept of body-stories could bring this extra dimension in, in a useful way.

Finally, I believe that a key aspect of the future development of CAM professions is the production of a research culture. By understanding the knowledge base of some CAM therapies, the value of randomized controlled trials is undermined because the therapeutic intervention is so clearly bound up in the individual bodies of the patient and practitioner and their interactions. While research is beginning to be recognized within CAM as a key method of legitimation, there is too often a short-sighted understanding of research as being about ‘scientific proof’. There needs to be increased collaboration between different sectors of health care, and practitioners need to work with academics to identify research methods that are appropriate to their practice. Today, issues of lack of training, poor understanding of research practices, lack of funding and impetus, plus negative perceptions of research (as evaluation, unhelpful to practitioners, time-consuming) disinclines people from participating in or promoting research.

Areas for future sociological study

Although the focus on the training of practitioners was an ideal setting for making explicit the embodied knowledge and skills that underpin day-to-day health care practice, questions about how the dilemmas of power in the patient-practitioner relationship are managed by students after they graduate and move into independent professional practice was beyond the scope of this study. This would be a useful topic for future study, and I believe that in any study of this nature it would be useful

to understand the impact of practitioner training on patient-practitioner interactions in the long term. In addition, the specificity of the case study colleges chosen is likely to have produced some results that would not be seen at other colleges or in other professions, so additional research in other CAM therapies would be productive.

It would also be interesting to investigate whether some of these findings could be generalized to other professions, such as the medical profession. The explicit validation of embodied knowledge in the educational environment is not universal. In addition, it is unlikely that all (healthcare) professionals develop an occupational habitus that includes reflexivity to the same extent or in the same ways as the osteopaths and homeopaths in my research. Some professions may, by contrast, learn to firmly separate both mind and body and their experience and that of their patient/client in their practice.

There were some topics that arose during the analysis of the data that is was not possible to explore in depth in the final thesis, because of the limitations of space and the need to preserve the internal integrity of the setting to take full advantage of ethnographic research data. It is my intention to explore some of these topics in future publications. Areas of particular interest are the significance that the application of an osteopathic or homeopathic understanding of the body would have for social theory, in particular, the idea of the body as a social agent capable of producing symptoms and expressing its dis-ease, and notions of interconnectedness between aspects of the social body, perhaps relating to Freund's (1988; 1990) theories about the 'expressive' body; the usefulness of emotional capital as a concept to challenge mind-body dualism, and the reasons why non-orthodox medicine is dominated by women on both sides of the therapeutic encounter.

Concluding remarks

In conclusion, this thesis has been able to contribute to our empirical understanding of the knowledge base and practice of CAM therapies, and has been able to offer further theoretical insights into the nature of embodied knowledge and the importance of considering embodiment in the sociological endeavour. Through a detailed description and analysis of the learning experience of student practitioners, I have given in-depth consideration to the development of osteopathic and homeopathic knowledge. Drawing on the growing body of sociological literature on embodiment, particularly the ideas of Bourdieu and feminist critiques of his work, it was possible to conceptualize the student's educational development as the production of an osteopathic or homeopathic habitus that incorporates unique ways of knowing and perceiving the body in health and illness, and ways of acting to bring about healing. I have argued that no study of healthcare practice or education can seriously ignore the issue of practitioner embodiment. It is so fundamental, not only to the knowledge base of the profession, but to understanding the play of power in the healthcare field.

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Appendix 1

Consent Forms used at the College of Osteopathy

Date:

Location:

I confirm that Nicola Gale has provided me with an information sheet about her research and talked to me about participating in classes. I consent to her attending this class/ lecture/ clinic session as part of the research that she is conducting for her PhD. I understand that she will use pseudonyms to protect my identity in her thesis and any published work.

Signed:

Email:

Appendix 2

College of Osteopathy Course Structure and Assessment (in brackets)

(Student Handbook)

First year: Orientation phase

Structure Function (SF) (30 credits) – Large focus on anatomy – including muscular anatomy, anatomy seminars, embryology etc (*course work and written exam*)

Function Dysfunction (FD) (30 credits) – Tutorials and lectures (*open book exam, written exam*)

Practical Osteopathic Skills (POS) (30 credits)- technique (lectures and tutorials), interactive anatomy (*Formative OSPE, and Summative OSPE*)

Conceptual Basis of Osteopathy (CBO) (15 credits) – concepts lectures (*3 assessed essays*)

Professional Capability (PC) (15 credits) – data handling (stats) and clinical competency (*data handling report, clinical competency report*)

Assessment is a combination of course work and examinations

Second year: Consolidation phase

SF (30 credits) – Child Development, NMS lectures and tutorials (*course work, written exam*)

FD (15 credits) – (*open book exam and written exam*)

POS (30 credits) – Technique classes, IMS lect/practical, applied technique (*formative and summative OSPE*)

CBO (15 credits) – lectures (*critical reading exam, sociology written exam, short answer question paper*)

PC (30 credits) – DCP lectures, Ost Evaluation and Diagnosis, Communication skills, clinic observations in summer term (*OPSE questions, tutor reports, clinical competency report*)

Summer holidays – four weeks in clinic.

Third year: Integration and Synthesis phase

SF (30 credits) – Neurology, NMS tutorials, (2 *written exams*)

FD (30 credits) – Pharmacology, respiratory exam prep tutorials in summer (2 *written exams*)

POS (30 credits) – Rehabilitation technique, technique (HVTs) (*Formative and summative OSPE*)

CBO (15 credits) – developing own clinical style

PC (30 credits) – Clinic work (2 half days) (PMP, OSCE, DCR Practical exam, Literature review)

IE – Research Method Proposal

Summer holidays – four weeks in clinic

Fourth year: Pre-professional

Individual Enquiry (30 credits) – Study skills (*Paper and Presentation*)

FD – visceral studies

POS (30 credits) – Technique tutorials, applied technique, IMS lect/practicals (*SWOT analysis and action plan, Viva, CTM Report and Technique, Portfolio report, ATA, Viva 2*)

CBO – Case Study ('the concepts case' – *written report and presentation*)

PC – (45 credits) clinic work (4 half days) (*clinical competency reports, final clinical competency assessment, clinic tutor reports*)

Appendix 3

College of Homeopathy: aims of the course

(college website)

1. Balance 'inner' learning with 'outer' learning

We believe that the process of becoming a good healer is as much about an inner journey as it is about learning information and skills. So as well as teaching the necessary content we place emphasis on personal experience, building confidence and developing self-awareness.

2. Non-traumatic self-assessment

We believe that learning can be a pleasurable and empowering experience without placing an unnecessary academic burden on our students. We do not set exams on our courses, but instead we encourage students to develop in their own style and at their own pace by means of personalized learning journals and self-assessment.

3. Good staff-staff and staff-student relations

We believe that people both work and learn best in an environment where the interpersonal relationships are good. To this end we work hard at creating a supportive environment between ourselves as tutors, and in our interactions with students. We also encourage our students to work in a supportive and co-operative, rather than competitive atmosphere.

4. Open feedback channels

We firmly believe in listening to our students, and getting regular feedback from them. And we are willing to respond positively to the feedback we get.

5. Good support system

We have an extensive network of regional tutors who support our students with their casework and their development as practitioners.

6. Open-minded, non-dogmatic approach

Our tutors have a wide range of expertise and our curriculum is broad and flexible, allowing our students to learn the essentials whilst also remaining free to develop their own interests and skills.

7. Energetic framework

Homeopathy and flower essences are energy medicines. In order to use them to their fullest potential, we believe it is essential that our students have a practical understanding of the energy system and how it functions, both in health and disease.

8. Practitioner skills

We believe that healing is as much about the relationship between a practitioner and patient as it is about any remedies we might prescribe. We spend considerable time developing interpersonal skills and other useful practitioner skills.

9. Learning through experience

We believe people learn best through hands-on personal experience. Therefore we encourage and support our students to start practicing what they have learned as soon as they individually feel ready.

10. Self-responsibility

We encourage our students to take charge of their own learning process. In this way their confidence builds and they learn through their own experience how to empower their clients to take charge of their own health.

Appendix 4

General Osteopathic Council Requirements:

(GOsC, 1999)

- A** Knowledge relevant for the safe and competent practice of osteopathy
- B** Concepts and principles of osteopathy
- C** Therapeutic and professional relationships
- D** Personal and individual skills
- E** Communication skills
- F** Information and data handling skills
- G** Intra and interprofessional collaboration and co-operation
- H** Professional identity and accountability, ethics and responsibilities
- I** Professional self-evaluation and development by means of reflective practice
- J** Identification and evaluation of the needs of the patient
- K** Acquisition and enhancement of the skills of osteopathic palpation
- L** Planning, justifying and monitoring osteopathic treatment interventions
- M** Conducting osteopathic treatment and patient management
- N** Evaluation of post treatment progress and change
- O** Advice and support for the promotion and maintenance of healthy living
- P** Managing an efficient and effective environment for the provision of osteopathic health care

Appendix 5

Osteopathy Student Numbers

The following table shows the age and gender distribution of full-time students for all year groups (adjusted to show their age at beginning of the course):

Age Range	Male	Female
17-20	37	39
21-25	18	35
26-30	37	25
31-35	20	20
36-40	11	19
41+	11	9
<i>Total</i>	<i>134</i>	<i>147</i>

N.B. This detailed information was not available at the College of Homeopathy. Approximate details are given in Chapter Four.

Appendix 6

College of Homeopathy – Criteria for assessment of the case studies

(Student Handbook)

Case taking

The ability to obtain sufficient relevant information. This should include mental characteristics, emotional states, physical generals, personal history, alongside a description of the presenting complaint. This information should be organised in a way that the case assessor can read the information easily.

Overview and understanding of what needs to be treated

The most important decision is about whether to treat the person or part of the person. This could involve treating a chakra, the disease process, or an organ.

Evaluation of symptoms

The ability to evaluate the most important symptoms that relate to the decision about what needs to be treated.

Repertory

The ability to be able to translate the language of the client and the symptoms of the case into repertory rubrics.

Differentiation of remedies

The ability to be able to choose a remedy or a number of remedies by comparing and contrasting the top remedies that cover the aspects of the case.

Justification of remedies

The ability to bring a wider understanding of how the chosen remedies fit the case.

Potency and repetition

The ability to choose appropriate potency and frequency of repetition within the context of what you are treating.

Follow up

The ability to decide on an appropriate time scale for when to do the follow up session.

Prognosis

The ability to have some idea of what is likely to happen when the person takes the chosen remedies.

Additional treatment

The ability to suggest additional means of helping the person's health in general or specific ways. This may included flower remedies, dietary supplements, lifestyle changes, relaxation techniques, learning meditation techniques, learning yoga, tai chi etc.

Remedy reaction

The ability to appropriately evaluate the responses to the remedies that were prescribed.